MEDICARE DRG'S LONG-TERM CARE: EFFECT ON RETIREMENT INCOME SECURITY

HEARING

BEFORE THE

SUBCOMMITTEE ON
RETIREMENT INCOME AND EMPLOYMENT

OF THE

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HOUSE OF REPRESENTATIVES

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MEDICARE DRG'S LONG-TERM CARE: EFFECT ON RETIREMENT INCOME SECURITY

MONDAY, JUNE 17, 1985

House of Representatives,
Select Committee on Aging,
Subcommittee on Retirement
Income and Employment,
Montpelier, VT.

The subcommittee met, pursuant to notice, at 9:30 a.m., in the Pavillion State Office Building, State Street, Montpelier, VT, Hon. James M. Jeffords (acting chairman of the subcommittee) presiding.

Members present: Representatives Jeffords, Hertel, and Blaz.

Staff present: Nancy Hobbs, minority staff director; Bernice Murray and Stacy Littlefield of Representative Jeffords' staff.

OPENING STATEMENT OF REPRESENTATIVE JAMES M. JEFFORDS

Mr. Jeffords. This hearing of the Subcommittee on Retirement Income and Employment will come to order please. Today we are here to assess the impact of prospective payment on the quality of care in Vermont. We want to know how the DRG price system is affecting our policies for long-term care. We hope to look at the impact of prospective payment not only on hospitals, but also on the demand for alternatives to hospitalization such as nursing homes, home health and homemaker services, respite care, and outpatient services.

Due to the number of witnesses, I must request that you limit your oral testimony to 5 minutes. In order to be fair to the later witnesses I will have to be strong on that aspect. Longer statements may be submitted for the record and will appear in the record. Also, we will keep the hearing record open for 30 days after the hearing for anyone who wishes to submit additional materials.

First, I would like to introduce my colleague, Ben Blaz, Delegate from Guam, who serves on the Select Committee on Aging as well as two other very important committees, the Armed Services Committee and the Committee on Interior and Insular Affairs. General Blaz, a member of the Marine Corps for many years, is the first Republican to serve from Guam. He is a very articulate man and was elected as the head of the entering Republican freshman class. This is an honor because all of the new Members of Congress are sure that they are the most important, but finally leadership sifts down to the one who can bring a consensus. This position not only makes him the leader of the freshman Members who are entering Congress, but is also important with respect to the assignment of freshman Members on committees. And, so, it is a great honor to have been chosen as the Freshman Republicans' leader and I want to recognize that publicly.

We are waiting for Congressman Dennis Hertel of Harper Woods, MI, a three-term Democratic Member of Congress. I will further introduce him when he arrives.

The recommendations of the witnesses we will hear from today will be shared with the entire Select Committee on Aging as well as other committees with an interest in health care. During the last Congress, field hearings in Vermont on the Social Security disability program were instrumental in the passage of the Disability Reform Act of 1984, which improved the appeals and review process for determining disability. I am certain that your remarks today will be useful in bringing about Medicare reforms.

First, let me introduce to you General Delegate Ben Blaz for any remarks that he would like to make at this time.

STATEMENT OF REPRESENTATIVE BEN BLAZ

Mr. Blaz. Presumably you want the remarks, Mr. Chairman.

Mr. Jeffords. That would probably be more helpful.

Mr. Blaz. Let me start over by just saying how enraptured my wife and I were over your State and, quite frankly, I am showing my ignorance by not realizing what a magnificently beautiful place it is and so clean. I have never seen a place so clean. I would like to think you cleaned it up for us, but I am sure you did not. But it really was so, so beautiful.

Let me also say that one of the great commonists in the Marine Corps, I do not know if you know this, was Gen. Wallace Green. I worked for him, and he was from Vermont. So, the State has contributed to my call.

Let me commend you publicly for the initiative for holding this hearing. Quite ironically, the territory, my district, the Territory of Guam, I find out, is very similar to your State in the sense that we are also a rural community. We have an elderly population and the urbanites, you know, seem not to appreciate the kind of problems that we have. Either you are taken care of in the hospital in Guam or you have no other place. And, fortunately for us because of our culture derived from years and years of Spanish occupation, the home is quite used. There are no facilities outside of the hospital, so, it is the home. But I can understand how that would be very difficult to continue or to even institute here if it is not already instituted. But for my part, I am really all ears. Medicare reform, this business of prospective payments, this whole thing is new to me. I think it is said in the Congress that one of the beauties of going on a field trip is that you get firsthand knowledge from onsite witnesses, or some people characterize it as eyeball witnesses. They tell it to you and you go back and you relate not only to this committee, but the various committees, such as Ways and Means, Energy and Commerce, and the respective departments that are involved in the Federal Government.

I should also like to mention in case you all do not know that your Congressman here is not only very interested in the problems of the aged as he sits on the Select Committee, but as a ranking member of the Education and Labor, he is also in a position, and a very unique position, to look over the Older American's Act and the many subdivisions of that. So, there is more to the hearing here than may be obvious to you. I am glad to be here. I am looking forward to hearing the testimony and, better than that, to be in a position to help convey the message of the elderly in hospitalization matters to the appropriate agencies in Washington.

Mr. JEFFORDS. Thank you very much. I also know that in the brief time you have been here you have covered more of Vermont with your wife than many people see in a lifetime. I greatly appreciate your interest in seeing what we have here in this beautiful State.

We have a difficult challenge confronting us in health care today. For the individual, the challenge will be meeting tomorrow's health care needs with rising out-of-pocket costs and reduced benefits. For Congress, the challenge will be meeting tomorrow's health care needs with rising costs, in view of Medicare's threatened insolvency and the rising Federal deficit. Major causes of rising Medicare costs include increases in the use of health care services, price inflation in medical care and advances in technology.

The new Medicare prospective payment system, designed to reduce hyperinflation in health costs, is receiving mixed reviews. Some hail the success of this program in preventing or postponing the bankruptcy of the Medicare part A trust fund. The hyperinflation in hospital costs has been reduced from 16 to 5.4 percent since PPS was instituted. Private health insurance has followed Medicare's lead in instituting cost containment measures. Some have hailed the shorter length of stay in hospitals and declining hospital admissions as a welcome change from overutilization of hospitals. Some believe that the accounting and management reforms that hospitals have instituted to comply with the intricate prospective payment system are making hospitals more efficient. Are these trends a result of prospective payment or of competition?

On the downside of the prospective payment picture, the shorter hospital stays have been portrayed with anecdotes of dumping elderly patients into a system replete with gaps in alternatives to institutionalization. The decline in hospital admissions has been linked to long waiting lists for skilled nursing facilities. The increase in the use of outpatient facilities has been described as creating logistical problems for older persons and the disabled.

We are hearing from small, rural community hospitals that these trends are creating gaps in access to care and in the quality of care. We are hearing that these hospitals are treated unfairly because of the rural differentials and wage indices under prospective payment. In fact, some rural and community hospitals are having a hard time making ends meet under prospective payment.

On the other hand, for profit hospital management chains, like Humana are showing substantial profits and are announcing bold expansion plans. The Hospital Corp. of America's net earnings for September 30, 1984, which are representative in the industry's, rose 21 percent, year to year, and its net margins widened to 6.9

from 5.9 percent. This is according to analysis by Standard & Poor's.

Investor-owned for-profit hospital chains may weather the DRG storm by keeping costs below the DRG rates, through volume purchasing, access to substantial investment capital and high turnover in patients requiring expensive procedures. No one is opposed to efficiency and competition in health care, if quality is not sacrificed and if subsequent needed nonhospital care is available and affordable.

I remain concerned that refinements or changes will be required in our prospective payment system if it is to be truly responsive to the health needs of the elderly. If older persons are going to be forced out of the hospital sooner, then believe we must develop long term care policies that fill the health care need gaps. Perhaps in one rural community, we need more home health care agencies or more flexible Medicare reimbursement policies to allow greater access to existing home health care agencies.

In another rural community, a hospital swing bed program and a skilled nursing facility may be inadequate to meet the long-term care needs of the elderly. Perhaps this community needs additional Older Americans Act title III funds or title XX funds for homemaker services. The hospice program may also fill gaps in our communities. On the other hand, hospitals can help, too. Many hospitals are expanding into home health care, hospice, and skilled nursing fields. The medical profession can also recognize their role and hold down costs.

Nationwide, skilled nursing facilities are overcrowded. Home health agencies report a 50-percent increase in referrals. Community hospital admissions are down. Hospital outpatient services are increasing. The bottom line is that consumers are experiencing higher out-of-pocket health care costs.

Rural hospitals are often the sole source of community health care services and they are beginning to feel threatened. Are these problems in our long term care policies the result of flawed legislation or the natural outcome of competition? Are these issues trends or aberrations?

I am here today to hear your views on how Congress should amend the Medicare and Medicaid laws or suggest regulatory changes to refine the prospective payment system. I hope this hearing will have the added benefit of helping all members of the health care community recognize their role in making our long term care system more responsive. The solution rests in seeing the issue as a Federal, State, and community concern.

With that, again, before I introduce the panel of witnesses, I would remind everyone to try to keep their statements to 5 minutes and I will try to give you a 30-second warning as we near the end. And then I would ask you to summarize or to come to a quick-as-possible halt. We will listen to the members of the panel and then ask questions of the members of the panel after they have completed their statements.

The first panel, made up of Faire Edwards, senior advocate from the Green Mountain Chapter of the Older Women's League, and Margaret Whittlesey, the AARP legislative chairperson from North Hero, VT. Please take your seats.

Faire, as always, it is a pleasure to have you appear before our committee. You always give us an excellent and articulate summary of the problems facing seniors and often give us the solutions that we need. So, it is a pleasure to have you with us; please proceed.

PANEL ONE: CONSISTING OF FAIRE EDWARDS, LEGISLATIVE CHAIR, GREEN MOUNTAIN CHAPTER OF THE OLDER WOMEN'S LEAGUE, AND THE VERMONT STATE COUNCIL OF SENIOR CITIZENS, WATERBURY, VT; AND MARGARET WHITTLESEY, AARP LEGISLATIVE CHAIRPERSON, NORTH HERO, VT

STATEMENT OF FAIRE EDWARDS

Ms. **Edwards**. Thank you, Jim. In the first place, let me say that I am not sure there are solutions to all of this and we should have been thinking about them about 25 years ago.

Thank you for this opportunity to speak. I am Faire Edwards of Waterbury, VT, legislative chair and volunteer publicist of both the Green Mountain Chapter of the Older Women's League and the Vermont State Council of Senior Citizens, which is affiliated with the national council.

The diagnostic-related grouping method of limited Medicare hospital utilization inevitably damages more women than men. First, there are more women, since we outnumber them by 3 to 2. Our life expectancy is longer and women are, by tradition, the care givers. While some men do an excellent job of taking care of sick wives, numerically, it is the other way, too. More than half the women over 65 are widows. In today's society, many live alone with nobody in the home to take care of them in the event of illness.

Within my memory—I am 73—this country had a simpler definition of what is "need for hospital care." It was the need of getting the patient able to go home safely, or at least ready to move on to a nursing home. Now that definition has been changed without ever having any opportunity to testify about what we consider our needs to be.

We were never asked whether we wanted our hospitals to go all over high-technology. Shortage of help during World War II and the subsequent development of antibiotics, led to a technique of patient care which often underplayed the important role of the nurses in a more personal method of care and patient evaluation. Machines and silicon were substituted for traditional nursing skills, to the point where the role of the hospitals moved toward crisis intervention, rather than helping a sick body recover more naturally.

Then came the study of a general population, which was I have heard, designed for curriculum development for medical schools, but was applied to hospital utilization on a different population than the patients studied. I refer to the New Jersey study from which DRG groupings suddenly became a standard for the needs of almost every person in this country over age 65. Without much in the way of testing on smaller groups, it was a nationwide experiment.

One study of the DRG review standards, by Drs. Berenson and Pawlson of George Washington University, is reported in volume

30, No. 11, of the Journal of the American Geriatric Society. I am sorry I could not find my copy of this to give it to you. It explained that in adjusting from a general population to a geratric one, three factors were considered worthy of making adjustments: First, age if the patient is over 70; second, number of comorbidities, is not that frightening? And, third, the event of additional complications during the hospitalization. One, two, or three of these conditions would get the same degree of adjustment of the length of hospital stay permitted. And there was nothing mentioned about people who were older than 70, like 98 or something.

Since old people tend to gather up more ongoing health problems with the years, that was an unrealistic method of adjusting the length of stay permitted. Drs. Berenson and Pawlson cautioned that the more fragile patients would not be properly considered. In this area, the patient is expected to go home ready or not, when the paper review says so, even if she lives alone, up three flights of stairs and cannot afford a telephone. She is told she is no longer in need of hospital care.

The Home Health Nurses Associations complain that they are constantly being called upon for more sophisticated types of procedures. I have heard patients in other States who were expected to be given intravenous treatment of medications at home, but not here in Vermont, although I know of one agency which has been asked and is considering the question. In this climate, some homes are cold and cold IV fluids can be lethal.

Another problem here is the difficulty of entering a patient in the hospital without a specific diagnosis. My doctor explained:

> When an old woman, living alone, falls, she finds herself on the floor and does not know what happened. A day or two under the eyes of a competent nurse could give me the information I need to make the specific diagnosis, without which, unfortunately, she cannot get hospitalized.

How to improve this situation? First, we need to start quite a way back and look seriously at Medicare. The public needs a lot more information on what exactly Medicare is paying for. For example, an article in the New York Times recently stated that the CAT and the more sophisticated scanners and similar technology, had raised the increase rate of Medicare by 30 percent. Is this investment actually treatment, or is it a development in technology, worthy in itself, but, arguably in a different category?

Have we looked sufficiently at the illnesses and accidents which cost Medicare big sums? Could we have prevented or averted some of them? Only last Friday, I read in U.S.A. Today that the medication prescribed for my ulcer pain can steal calcium from the system and encourage osteoporosis. Broken hips can be expensive. Incidentally, the answer is "Tums," which gives calcium instead of aluminum.

At the 1981 White House Conference on Aging, the Committee on Wellness, I asked for a transfer of some funds so that Medicare B could pay registered dieticians to help patients avoid just this sort of misunderstanding. I was booed by some of the characters who had been brought in for political reasons. Yet many of the leading disorders requiring hospitalization can be slowed down by proper therapeutic diets.

Of course, we are all going to die; but if we stay independent as long as possible, we can be useful. In 1984, Retired Senior Volunteers, nationally, donated over 64 million hours of community service.

We need to give a good look at the effectiveness of Medicare's original text. The bill, according to Dr. Robert N. Butler, eminent gerontologist, was written as though for a 30-year-old patient. Is not it about time to bring it up to date? There have been a lot of new discoveries since then. You people know Dr. Butler. Why do you not ask him?

This is particularly important for women because, in addition to living longer, we have less money to live on. I have enclosed a chart showing the difference. Please, also remember that many of us who are up, about and active are still paying pharmacy bills around $1,000 a year for the medications which keep our chronic health problems under control.

Perhaps, more important of all, this Nation needs to come to terms with the demographic revolution we are in and have been since about the beginning of the century. Longevity for both sexes has increased dramatically, but more for women than men, due to good obstetrics and gynecology, which you gentlemen do not get in on. As of 1983, latest figures available, the median total dollar income for a woman over 65 was just over the poverty level, making any illness, especially with declining care from Medicare, more threatening. The sick lady cannot buy the services she needs and they are frequently not financed in any other way. Often, her daughters cannot afford to leave work to give her the help she needs. They know they will need recent work experience to earn their own way in the event of divorce or widowhood, now, statistically at age 56.

We also need more factual information about the assets and income. Most published reports show income of a couple, although more than half the women over 65 are single, usually widowed. Both incomes and assets of the old should be given as his, hers, and theirs, and carefully explained which is which. There is also a lot of misunderstanding about housing and the value of houses. These existing ambiguities could be cleared up, if you good people would insist that they must be.

Congress could also insist on the Administration on Aging, and other bodies of Government follow the goals and objectives of the Older Americans Act U.S.C., 3001—that is Act 42 U.S.C., et seq. Under Title I, Declaration of Objectives; Definitions: "Sec. 101 [10] Freedom, independence and the free exercise of individual initiative in planning and managing their own lives and full participation in the planning and operation of community-based services and programs provided for their benefit."

From the time of the 1981 White House Conference onward, we have seen an erosion of the principles stated in the Older Americans Act. If our local and State programs are discouraged from including informed elders in their planning or cannot discuss proposed services, or cuts in them, before the general public, the result will be both waste of money and, even worse, neglect of the needs of this sometimes very fragile segment of the population.

And, please remember, the women who have cared for their husbands and families are, indeed, most likely to be victims of misunderstanding and of the neglect which comes when the needs go unserved.

There is much that can be accomplished, but, first, we need a network which can and will listen, as you so kindly have.

Thank you. Any questions?

STATEMENT OF MARGARET WHITTLESEY

Ms. **Whittlesey**. I'm Margaret Whittlesey from North Hero, VT, and I'm here representing the legislative services of the AARP.

Hospital care, which involves part A of the Medicare Program has been given much attention recently as the experience in using the DRG system is reported. We need to keep in mind that the patient must pay a $400 deductible before the first 60 days of hospitalization are covered.

The testimony regarding part A and the DRG is going to be given today. It is important to consider the experience of patients who use part B of the program. This is designed to help pay for physicians' services both in and out of the hospital and such additional services as therapy and home health care are included in part B.

Persons who are enrolled in part B are responsible for a monthly premium which is withheld automatically from the monthly social security benefit payment. The amount of the premium is determined annually by statute that premiums must cover 25 percent of the cost of the program.

Consequently, as program costs rise, premiums must rise. Currently, the monthly premium is $15.50. The person who uses the program must pay first the first $75 of part B allowable charges in each calendar year, and second, the co-insurance for the allowable charges for the covered services.

Allowable charges are often considerably less than the actual charges, and the patient is responsible for payment of the difference. The exception to this requirement occurs when treatment has been given by a physician who accepts assignment. Such physicians are not always available in small communities. And some older patients prefer to remain under the care of a doctor who has treated them previously to assignment.

Provisions of part B pose difficulty for persons whose income is modest and whose assets are too great to permit them to qualify for Medicaid assistance. Such assets usually include ownership of a home which represents years of work, careful management of modest resources, and some savings.

Paying the annual premium, the annual deductible for allowable charges, the co-insurance, and meeting the difference between the actual allowable charges, places a burden on persons with modest incomes.

Many persons in this group cannot afford the cost of supplemental insurance and would rather go without, take their chances, rather do that, than to contract for an expense which they cannot afford. Staying debt-free is the top priority, and, therefore, these folks are faced with very hard choices.

Such persons often do not seek medical attention at the onset of illness, but postpone seeing a physician until they are quite ill. Serious illness for this group is a financial calamity, because it may force a person to spend-down resources.

We cannot document the full extent to which older persons of modest income postpone or fail to seek medical attention because of the costs involved. We know it happens. Persons who are acquainted with this group, such as pastors, outreach workers, personnel at senior meal sites, and others, have told us of such situations.

Part B falls into the tradition of covering costs for illness while disallowing costs for health maintenance. We are looking for ways to cut the costs of medical care. We need to look for ways to support health maintenance and early intervention at time of illness. This would, indeed, help to reduce costs. This suggests that there should be a new and creative approach to the provisions of Part B. We have the opportunity not only to cut costs of care but also improve the quality of life by finding a way to promote prevention through rearranging the Part B provisions, to support early detection and prevention. This could reduce appreciably the need for hospitalization.

And I would like to point out that the Part B covers the traditional way of meeting the costs of health care through insurance and it is just beyond the time when we should be more creative about helping people to meet the needs early on so that the cost of care will not be as great as it has been.

Thank you.

Mr. **Jeffords**. Thank you, Ms. Whittlesey.

I would like to introduce to you Congressman Dennis Hertel who is with us today. And I would like to thank him for coming to Vermont for this hearing.

Representative Hertel is in his third term and serves on the Armed Services Committee, the Merchant Marine and Fisheries Committee and the Select Committee on Aging. Welcome to Vermont. Please feel free to make such opening comments as you desire.

Mr. **Hertel**. Thank you very much, Jim. I appreciate all of your help and the staff's help. They do an excellent job and that is really a great group of people, very hard-working and very nice people.

It is great to be here with you and my good friend from Guam. Sorry I'm late. I had car trouble this morning and my rental car had trouble with the carburetor. But I've enjoyed the testimony so far because it is so important.

I'd like to commend Jim on his leadership, especially on senior citizen issues. His seniority is so important not only on the Aging Committee, but also as the ranking member on the Education and Labor Committee. That gives him the ability to make things happen in Washington. And he has been very instrumental in improving nutrition programs and delivery systems and also in maintaining and improving the Older Americans Act. Thank you for your leadership and assistance.

My district, the Detroit area, is an urban district—city and suburban. We have many senior citizens. In the State of Michigan and in my district, the population is aging very fast and we are facing many of the same problems you are facing here in Vermont. The northern part of our State is, of course, very rural and very similar to Vermont and so we share many of the same problems.

I think it is most important that we remind people in Washington of their priorities and the sacrifices senior citizens have made. The senior citizens of today are the people who fought two world wars at home and abroad. They lived through the worst depression, they lived through the highest increase in inflation, the highest increase in taxation. And through it all they have maintained and instilled in us all of the values that we find so important—the values of hard work. If we work hard enough we can do better and our children can have a better opportunity.

And that is really what I think government is all about, to help communities, to help individual citizens achieve a better life, have better opportunities, and that's why the work on the Aging Committee is so important. After people have made so many sacrifices they still have so much to offer to the rest of us. Their wisdom and experience, and sacrifices have made this country strong. We ought to remember that. And we ought to treat them fairly.

Let me say that in my State, the greatest problem for senior citizens is the one we are focusing on this morning, and that is the increased cost in health care and the difficulties people are having with requiring needed care.

People say that inflation is low. They are certainly not looking at health care because those costs have skyrocketed over the past few years.

And I just want to say that it is very good to be here and to be having this hearing. I don't think you can collect enough information about the problems older Americans are facing in the area of health care, and I don't think we can hear enough from them, and the people involved, the people who are working so hard in providing these services that are testifying today. I don't think we can hear enough about recommendations on what we should be doing in Washington.

Mr. **Jeffords**. Thank you very much, Dennis. We are pleased to have you with us, and I think we will find, as the time goes by, in these hearings, that there are many similarities between the real urban and the real rural, in the sense that these surroundings impact upon health-care institutions.

So I am sure that we will be able to work together and hopefully not have divergent interests here.

I also want to thank Margaret and Faire for their very excellent statements. And I would say you have outlined, both of you, some very difficult problems.

In your view, now, what is the most difficult problem we face today in terms of health care—first generally and then as a result of the DRG system. Faire, would you start?

Ms. **Edwards**. Survival, I think, would be the top problem. Can we live through what the Government is doing to us? I mean that quite seriously.

Perhaps most serious for us is the refusal of admission without a clear diagnosis when many times the hospital procedure—what is needed is to get the clear diagnosis.

Mr. Jeffords. How prevalent is that?

Ms. Edwards. Presumably you will hear from the Medical Society on it. I get a break from my own doctor, and I know some doctors come home practically jibbering after a day when they've been at the hospital. I heard that from the wife of one of them. And these are conscientious, competent practitioners. These aren't just any weak types. They are highly qualified professional men.

Mr. Jeffords. Margaret?

Ms. Whittlesey. I think that the top priority as far as I'm concerned is to reach people with good care before their problems become severe. I think a tremendous amount of hospitalization could be avoided and I think the quality of life would be far better and happier for those people. Down in North Carolina they have a program called Add Health to Our Years and the acronym is AHOY.

But I really feel that we, consistently over the years, have neglected that part of care. Back when the health department first opened its building on Colchester Avenue, which was in the early 1950's, Dr. Aiken pondered a great deal before he had the motto put in the lobby, "An Ounce of Prevention." And I think we've been more than 30 years without doing much about the ounce of prevention. And I think we need to give a lot of attention there, but the way in which insurances and payments for things are set up seems to mitigate against early intervention. So I have been pleading for us to take a hard look at how we might rearrange things so that we could indeed have some prevention, some early intervention to try to keep people well as long as possible.

Mr. Jeffords. Yes, I agree, Faire.

Ms. Edwards. I would like to see Vermont used as a statewide testing ground, to sit down with a list of costs of Medicare hospitalization and the 10 leading reasons and pick out the things that seem the most preventable.

Osteoporosis and its results are certainly logical things to consider in the various stages. But there are others too that are definitely related to diet alone, that I think could be addressed by various forms of communication.

Then the gentlemen seem to have prostate problems which one doctor tells me could be avoided or treated in the office if they would just go in time.

I am pondering where you would put up posters to that effect to reach the——

I haven't figured that one out yet. This is not my field.

But I think that if you sat down and picked out the ones that cost the most per person. Of course, now you are going to get loused up figures because you've got these people dumped out too soon. So you really don't know. Maybe you have to use some old figures. Like 1983 before October 1.

I think we have those lists. I went armed with one when I went to the White House Conference on Aging but those lobbies wouldn't let me talk.

Mr. Jeffords. Congressman Hertel.

Mr. Hertel. I just agree with what both of you said. The most important thing is that people work toward prevention. And that our programs are aimed at that. And it seems to me that what I've been hearing lately, with expenses going up for health care, people will sometimes have to put off going to the doctor or getting a prescription, et cetera. And that's the worst thing. It's expensive later on and it's more harmful to the person.

So I appreciate your testimony.

Ms. **Edwards**. The cost of medication is prohibitive and, once more, a generic drug will only help in a limited way, because most of the new medications are new enough that they are still under patent, so that you can't get—I mean other than digitalis, most of them are quite newly developed and I have had my medication costs run as much as $1,500 a year.

And when you consider that the average widow is probably getting $5,000 or less, sometimes considerably less, you can see that she is just not going to take all the medicine she should. Or else she won't eat, which is also bad.

Mr. **Jeffords**. Mr. Blaz.

Mr. **Blaz**. Thank you, Mr. Chairman. I just wanted to comment that I heard of the Vermont cheddar, that it was also peppered with Vermont puma. It is very refreshing and I am learning a lot and I don't know if I dare ask you a question. You might just come back with——

I think I'll just wait for the gentlemen to come up here before I ask my question

Mr. **Jeffords**. Thank you, Faire and Margaret, for your very excellent testimony and help in this difficult area.

Our next witness will be Joel Cook, director of the Vermont Office on Aging.

Joel, it is a pleasure to have you with us here today. You have a very important job that I am sure you are doing ably. We are looking forward to hearing your testimony.

STATEMENT OF JOEL COOK, DIRECTOR, VERMONT OFFICE OF AGING

Mr. **Cook**. Thanks for your kind remarks, Congressman Jeffords. I, however, am a little bit concerned based on General Blaz, your last comment. I know Faire and I know Margaret, and we all know them here as not typical senior citizens in the State of Vermont, but exemplary citizens of the State of Vermont.

I am very concerned, however, that you may take out on me what you might have wanted to ask Faire, in particular. I have learned over the years to listen to Faire and to not getting into too much of a dispute because you always end up on the wrong end, on the losing end. She is always correct whether you think she is at the time you speak with her or not, I think your decision to refrain from asking her questions is a wise one.

Now, on to the formal statement. My name is Joel Cook and I am the director of the Vermont Office on Aging. The office on aging is part of Vermont's Agency of Human Services, which is responsible for providing most of the formal services that we refer to as long-term care. I am here today to speak on behalf of the Agency of Human Services.

This hearing's theme is special and so is its location. You are gathered in the capital of a State the per capita income of which rarely rises above that of one-quarter of the States in this Nation.

You are in the capital of a State with only one standard metropolitan statistical area. Burlington and its environs comprise approximately 25 percent of our population, and our total population barely exceeds half a million. The population density in Vermont, for those of you trivia buffs in the audience, is approximately 54 persons per square mile.

You are also in a State that is quite proud of its agricultural heritage and is committed to protecting to the extent that it can its agricultural lands. With a few exceptions, major U.S. corporations simply have neither their headquarters nor divisions here in Vermont. We are, in short, in a number of ways a typical rural State characterized by a small tax base and a widely dispersed population in need of a wide variety of services.

Vermont, and Vermonters, are characterized by another trait tied to the theme of today's hearing. That trait is a love of independence. And for our purposes today I define that term as the capacity to work with the resources available to maximize one's ability to make it—to make it without undue assistance, without undue restriction, and without loss of dignity and self-esteem.

You will hear and already have heard to a certain extent from a wide variety of persons today describing from their personal and professional perspectives the effects of prospective pricing in the Medicare system, some good, some not so good. And you will hear about a wide variety of long-term care issues affecting elderly and other Vermonters. They can and will present these matters far better than I on behalf of the State.

What I think I can offer, from the State's prospective, is a brief analysis of the effect that changes in Federal policy, Federal social policy, over the past several years have had on this State and its ability to meet the long-term care needs of its citizens, and, by extrapolation, the effect of these changes on other largely rural parts of the United States.

We all know that Federal policy changes over the past several years have had far-reaching effects on the way we do business. There are, however, only two basic components to the changes whatever their costs may be. Those two components are an announced increase in flexibility in the way programs are administered and decreased Federal financial support for them. Our experience, and what we believe to be the rural experience, is that decreased Federal support effectively wipes out the benefits of administrative flexibility.

With respect to this flexibility issue, we generally agree it is good public policy to permit localities to tailor the manner in which they provide services to meet local needs. And, in fact, we are taking steps on the State level and in our local communities to do just that.

The problem we face as a rural State with a small tax base is that we can't meet the needs of all those requiring assistance without major Federal assistance. Our tax base is not large enough. This is where the New Federalism social policy falls woefully short. Congress traditionally has determined basic need levels that transcend State lines. Your commitment to meeting those needs from the national perspective is vitally important to rural America.

And I might add, I'm not familiar with the urban experience to that great an extent. But I imagine, in more ways than not, the needs of the elderly would be the same.

For example, the Omnibus Budget Reconciliation Act of 1981 created the social services block grants received by the States. With adequate funding, program priorities could have been met through the cooperative system. With respect to services for the elderly, the result has been reduction in adult services from our social and rehabilitation services department, elimination of health screening clinic activity related to the detection of such serious health problems as hypertension, glaucoma, and others by our health department, and termination of the development of mental health services for the elderly by our mental health department.

The answer for us does not lie in raising more taxes in Vermont. Here again, policies on the Federal level have made that virtually impossible. We have reached our limit. Our rural character holds remarkable aesthetic and environmental attractions. But it also seriously impairs the availability and increases the costs of essential services such as transportation, health care, and suitable housing. When Federal dollars for education, public assistance, transportation, and the like are reduced, State and local tax burdens reach their limit. The property tax burden in this State is nearly the highest in the Nation, and our current State budget includes provision for retiring a large but manageable deficit.

For us to be able adequately to meet the identified needs of our citizens in the area of long-term care, among others, Washington must readjust its focus. Abdicating some financial responsibility in social services to the States leaves many thousands of persons exposed. We are doing in Vermont what we can with what we have. But what we have in some respects is simply not enough.

Even as the New Federalism has altered financial and regulatory policies in the area of social services, programs which continue to be managed federally are making service delivery more difficult.

For example, in the area of long-term care, Medicare out-of-pocket costs continue to go up, we are discharging patients from hospitals in sicker condition, and we are facing regulations and financial policies making home care less viable. If hospital patients, by virtue of Medicare DRG's, are not able to recuperate fully in hospitals, then proper policy logically would support the increased availability of health services delivered in patients' homes. But HCFA has tightened the definition of homebound as a condition of eligibility for Medicare reimbursement and Congress and the President threaten to end revenue sharing. In this State, revenue sharing comprises 5 to 7 percent of the budgets of our home health agencies.

Ultimately, we in Vermont believe that every Vermonter is a person of worth and should be treated as such. Every American has value as well. Our national policies should reflect that value.

I decided to speak about these matters of financial policy and regulation because they are tied to the availability of services to the disabled and to the frail elderly. Most of the other persons appearing before you today will not talk about general Federal policies. We could also talk about tax reform proposals under your consideration. But for now, I think it more important to allow you to move on to consider more directly the matters under consideration.

I thank you for your attention and I can offer to supplement this testimony with some statistical information. On behalf of the Agency of Human Services, I will remain available during the balance of today's hearing to assist you in any way that I can.

Thank you very much.

Mr. **Jeffords**. Thank you for an excellent and perceptive statement. You have outlined some very serious problems facing the State of Vermont.

I would like to inform my peers here that the State of Vermont has one of the lowest per capita incomes in the United States. I think that when you adjust for cost of living, Vermont ranks 48th in the Nation. And yet, because of our location, our costs are extremely high, and the tax burden on our citizens is one of the highest in the country. Thus, our ability to be able to adjust to a cost shift from the Federal Government to the local community is very limited.

I would like to ask some questions to throw some light on the problems we are discussing today, although I'm not sure you will be able to answer.

On the national level Medicare costs have almost doubled in the last 4 years. The total amount of money being paid out of the Federal budget has grown from $30 billion to close to $70 billion. The question we all have, I guess, is that if additional money is spent, would we see an improvement in health care? It seems to me from what I am hearing here and what I have heard in Washington is that we seem to have more problems than we had a few years ago, notwithstanding the fact that we are now spending a great deal more money on Medicare.

I wonder if you can give me any idea whether this is the case in Vermont, and if so, if you have any idea why that is?

Mr. **Cook**. I'm glad you prefaced the question with, "I'm not sure you can answer it," because I'm not sure I can answer that. My impressions, and these are firm impressions, are that there are a number of people here who can address that question directly; but second, I don't think that in this room or anywhere that you can find wholesale disappointment or disagreement with the aims of the respective price increases for Medicare.

I think that we are all aware of the incredibly important function and purpose behind attempting to get some degree of control on health care costs.

Part of the problem may relate to the fact that prospective pricing only affects Medicare patients and not hospital patients generally. In fact, it may go beyond that and affect the health care insurance system.

We don't find ourselves enamoured of what amounts to cost shifting in this system. We're really not controlling costs in the aggregate, as you quite clearly understand, we are controlling out of whose pocket the money is coming.

Our view, and the view that I know you ultimately do have with respect to longer term care, is that the more of it that can be provided on the community basis, the better.

And I address that very briefly in my statement that we need to concentrate more on providing funds and making the regulations more consistent with our ability to provide those services in the community where we know, in more cases than not, that the services provided are less costly to us in the long run.

Mr. **Jeffords**. The previous witness has indicated that the area that needs the most attention overall is prevention. The problems that we hear most about are the result of inadequate long-term health care in the sense of the gap between the acute hospitalization-type care and nursing home care.

I am curious as to what your observations are. I suppose the two problems can be related. If we have to focus our attention on some increased funding, the question is where should it go? And, if our priorities are not established correctly now, how ought we to reorder them? And I would appreciate your comments.

Mr. **Cook**. Prevention is to all of us extremely important. It is probably most important in the entire area. If we have adequate programs that educate people on how to keep their health and maintain their health, we don't have to spend large amounts of dollars on problems that are incurable with respect to people who don't take care of themselves. That is a given.

Prevention is, independent of everything else, extremely important. With respect to people who are in need of some services, however, what we are trying to do here in the State, is on the statement. What seems to me illogical for you on the Federal level is discontinuing the services. That is the shorthand way of describing the range of services that we can identify with people in need. That continuing service is what provides us choice and what allows us to retain our independence, our dignity and self-esteem.

We have a service delivery system, that, although we refer to it as a continuum, has significant numbers of gaps in it. And to the extent that we can identify the gaps, we can identify the absence of choice in people's lives.

And to my way of thinking, we should spend a significant effort on identifying these gaps, closing those gaps, providing services particularly on the community level, the noninstitutional level to assure the people who don't need expensive forms of care which do not encourage and promote dignity and self-esteem and self-worth. We should provide the funding that is necessary to provide the services that are needed.

Mr. **Jeffords**. Congressman Hertel.

Mr. **Hertel**. Well, I just think you are doing an excellent job with an impossible problem. That is, if you have requirements for increased services, increased costs in that area, you are servicing more people, and yet you don't get any more money. So it is a very hard job and I commend you for laying it on the line today.

Mr. **Cook**. Thank you for the commendation. Apart from that, I think your summary statement was excellent.

Mr. **Jeffords**. Congressman Blaz.

Mr. **Blaz**. I just want to comment on your remarks. I have never heard a problem on—assistance laid out so well.

Let me ask you a question. In some States that I've visited—in the States that finance those institutions, they go through the process of literally getting rid of all of their holdings. They turn back their money to their children and they declare themselves paupers and then they put themselves in the hands of the State.

At the risk of sounding like I'm accusing somebody, is that done in this State, and if it is, don't you think that something should be done to correct it because it is becoming an epidemic in some sections?

Mr. COOK. What you have described is what other people have called "our national long-term care policy."

We have a national level policy in the United States which provides care to a certain extent for a few care problems. Beyond that, if people are in need of services, we require them, we don't allow them, we require them to impoverish themselves and then we'll provide them with services we'll say they need. That's the Medicaid system.

So, although what you are describing as an epidemic may reflect reality, it strikes me as more important for us to analyze the direction from which these steps take place. And why it is that people are divesting themselves of their homes and resources built upon a lifetime of effort.

We don't have a national policy that helps people unless they are impoverished. People need services and so they do what they have to to qualify.

I would not want to be heard as saying that Vermonters as a general rule read the Medicaid manual and see that they have to divest themselves of all but $6,000 worth of resources. And do so immediately. That is not what Vermonters and I think the people in the national generally do. But there is a point in people's lives when they realize or people on their behalf realize that assistance isn't otherwise available and they do what they need to to qualify for the assistance that is now being made available through the state and national economy.

Mr. BLAZ. Well, sir, thank you.

Mr. COOK. Thank you.

Mr. JEFFORDS. Thank you very much, Joel. We appreciate your taking the time to testify.

Our next panel is Dr. Ronald Ferry, a physician of central Vermont; Dr. Butsch, a physician of central Vermont; and Dr. LeGrand Burns, a physician of central Vermont. If they would come forward?

And also Dr. Reynolds. We have a group of physicians here who are, very concerned over the Medicare DRG's. Much of their concern centers around the Federal Government's intrusion into the decisionmaking process of the medical profession with these charges.

And also I believe they have with them two patients and a short slide-show presentation. Is that correct?

Dr. PERRY. Video.

PANEL TWO: CONSISTING OF DR. DAVID BUTSCH, MORETOWN, VT.; DR. RONALD FERRY, MONTPELIER, VT; PHYSICIAN; DR. LEGRAND BURNS, BARRE, VT; AND DR. REYNOLDS, CENTRAL VERMONT

STATEMENT OF DR. DAVID BUTSCH

Dr. BUTSCH. I would like to thank Congressman Jeffords, Congressman Blaz and Congressman Hertel very much for this opportunity to be here today, and in particular for their taking the time out of their busy schedules to come here to listen to each of us. I would like to thank Congressman Jeffords' staff for being so helpful in setting up this meeting. We are here to discuss health care among other issues and, in particular, the manner in which health care has recently been affected by new Government laws and regulations. There is no question that changes in the way medicine was being delivered were necessary, and it is fortunate that through the efforts of our Government that some of the changes have come about. I feel that there are many things that are now better because of the new laws and regulations; however, like some new systems, the present system does have some serious breakdowns, and I would like to discuss some of them in detail.

There are three areas of concern that I would like to address, and to be as specific as possible in the hopes that some change can be wrought. The first area that I like to discuss is the assumption made under the new regulations that if a procedure can be done as an outpatient procedure, it should be done as an outpatient procedure. I am speaking particularly now about Medicare patients; generally speaking, patients over the age of 65. We have lists of what procedures will be reimbursed on an outpatient basis, and we are told that in some cases exceptions will be made and the procedure can be done on an inpatient basis. Where the problem arises is that the physician is essentially told that the procedure should be done on an outpatient basis, but that if he can present a cogent argument that the procedure should be done on an inpatient basis, he can hope the hospital might be reimbursed on an inpatient basis when the case is reviewed later.

The review mechanism is somewhat cumbersome and extremely judgmental and subjective, and that mechanism determines whether payment will be made. In the meantime, the patient's care has already been rendered and the hospital and other individuals have already expended time and money with no reimbursement.

To take two cases in point, I will discuss the procedure of a barium enema. A barium enema, on the surface, is certainly a fairly straightforward procedure. It is a diagnostic test done generally on an elective basis. The preparation, on some people's minds, does not seem to be very stringent and can easily be done at home. But for those people that have had a barium enema, it is a little different matter. One suggestion might be to have all the members who have had anything to do with this regulation have a barium enema and then reconsider the manner in which they have handed down the regulation. I personally can think of a few of the regulators on whom I would be glad to order the procedure. At any rate, a barium enema involved preparation which is mainly a cathartic, and in elderly people, it can severely deplete their system of water, among other substances.

I can cite two patients who had their barium enema preparations according to Government law and regulations. One of them was approximately 80 years old. He is in good health and he lives alone. Like many Vermonters I have met, he is extremely independent and capable.

On the morning that he was to come to the hospital to have his barium enema, he was somewhat tired because he had been up most of the night preparing for the test. He was dizzy that morning in his kitchen and fell to the floor. Somehow, he managed to get up and drive himself to the hospital in his 25-year-old Studebaker and soon after arriving at the hospital, he had an obvious occlusion of the circulation of his leg. He had to have emergency surgery which in his case was somewhat difficult because he had had previous vascular surgery. The end of the story is good in the sense that he survived his surgery and still has his leg, but it was a harrowing experience.

Another similar case is that of an approximately 67-year-old woman who came in for her barium enema and went into shock and had to be admitted to the emergency department to have intravenous fluids. She was sent home later in the day and, fortunately, did well.

Now, the logical question is, "Why were not these patients admitted to the hospital, especially if we knew they were going to have trouble?"

The answer is simple enough. First, it is hard to predict who is going to have trouble and, secondly, as physicians we are strongly urged to order these procedures on an outpatient basis. Thus, we are always on the defensive, always thinking of a way to justify something, always trying to second guess the regulators or hired guns who make the final judgments on what should be done after everything is done.

An interesting sidelight is that one of these patients I have mentioned is due for a repeat examination this year because of what was found last year. He has already told me that he does not really want to have it done, and I have already told him that I also feel reluctant to order it because I feel nervous about what happened last year. I imagine we will do it. I imagine we will do it on an inpatient basis and I would certainly hope that the reviewers would allow it.

But it is unfair, I think, to be practicing medicine in such circumstances, because the position of reimbursement influences our decisions so strongly.

It would seem reasonable to offer a solution to this problem; however, it is not simple or else it would have been reached sooner. I would like to suggest, though, that the principles be changed, that, namely, the principle that anything that can be done as an outpatient should be done as an outpatient. Perhaps the wording should be, certain procedures are strongly recommended to be done on an outpatient basis, but may be done on an inpatient basis. Unfortunately, such a change would probably be offensive to the HCFA administration simply because from their point of view, it would be more expensive.

The second area of concern I would like to discuss is the manner in which patients' hospital stays are denied. Either their entire stay is denied or some of the days that they were in the hospital is denied. The facts show that in Vermont, patients have never stayed in the hospital as long as they have in other States—in most other States. And, now, they are staying even shorter periods of time. So, what happens when occasionally a patient is discharged from the hospital perhaps too soon and is readmitted? As likely as not, their readmission will be denied. It will be deemed unnecessary by a reviewer.

I would like to mention an example. This is a case of an 83-year old lady who had two major operations performed semi-electively at the same time. She had been in the hospital several months earlier because she had had a gallbladder attack and an esophageal ulcer. At that time, surgery was not considered because of its high risk and she was informed that she would do better to live the way she was than to run the risk of surgery.

However, approximately 5 months later, the lady stated she would rather die than live the way she was because of her recurring attacks of abdominal pain. Well, those are not bad odds for a surgeon when the patient says that they would rather die than live. So, we undertook the operation. Fortunately, the lady did well except for several major complications. She developed pneumonia; she developed a small wound infection; and she had a bladder infection. I think it is fair to state that some of these complications were due to her age and her nutritional state. She did have her 84th birthday while she was in the hospital. So, we can say the good news was she made it to her 84th birthday, but the bad news was she was not able to eat her birthday cake.

She did improve and was eventually discharged to a level III care home after 16 days in the hospital. Her alotted time in the hospital, according to the DRG system, was 7 days. That 7 days was supposed to take into account the fact that her surgery had been refused 5 months earlier because she was too high a risk to undergo surgery. And it was felt that she might not survive. That same 7 days was supposed to take into account the complications she had because we registered these complications at the time that we discharged her and submitted her bill.

At any rate, she did not do well at home. She did not eat well. She was nauseated. She vomited frequently. Her caretaker called her family practitioner and the family practitioner was unable to improve her situation with medication and advice. Eventually, she called her surgeon and was readmitted to the hospital 4 days after she was discharged. Her caretaker was unable to take care of her at home. She was now treated 2.5 days in the hospital, starting on a Friday night and was initially given intravenous fluids. She improved and was discharged.

[And in a minute, I would like the first slide.]

When her chart was reviewed twice by outside reviewers or hired guns, they felt there was no need for readmission; in fact, the final reviewer who reviewed the original reviewer had the audacity to say that she could have been well cared for in a level III home. I will quote from his record.

Here is the reviewer's review of the original reviewer who was reviewing me. It should have been anticipated based on the initial findings that the patient was unlikely to need more care than could be provided in a level III facility.

The end of this story is certainly a good one, but on the other hand, our hospital paid the patient's bill the second time around and the Government refused. At some point, we physicians may begin to follow the Government's medical cookbook, strictly. And then we will have to refuse patient care in situations like this. We will have no choice because the hospital will not allow us to admit outpatients.

As physicians, we receive monthly reports on how much we are making for the hospital or losing for the hospital. It is so-called peer pressure. It is probably good but it has bad side effects. When the peer pressure is strong enough, we will not admit ladies like this one I have spoken about. We will say over the phone, "Undoubtedly, your care can be handled by an antinauseant and dietary modifications." And we will leave her at home, especially on a Friday night in Vermont.

What is a better solution? I feel that more trust has to be accorded the physician who is taking care of patients. Sound medical judgment and compassion have to play a role. They are not playing a role, now.

The third area of concern I would like to bring up is unfortunate but necessary, and that's the area of financial reimbursement. We have a rigid system that has been instituted and gross inequities have been brought on by it.

[Could I have the third slide?]

Mr. Ray Shatney is an 82-year-old Vermonter with pancreatic disease. On presentation to our hospital, he was severely malnourished and according to the Government cookbook, his care could be completed in 20 days. It is inconceivable in my experience for an individual in his state to be nursed back to health in such a short period of time and, in fact, Mr. Shatney was in the hospital 37 days. On a previous admission 4 months earlier for the same condition, the Government failed to pay $10,000 of his bill. On this admission, it would be obvious, again, that his bill would not be paid in full and it was not. This time, the Government did not pay $5,000. Mr. Shatney is here today as living testimony to the adequacy of his health care and to the unfairness of the Government reimbursement system. I doubt if he would be alive today if we had followed Government regulations.

I would like to conclude with three questions. First, were medical expenses so exorbitant that the present oppressive, somewhat dangerous system is justified?

Second, is our Government proud and are you, Congressmen, proud that in many cases medical expenses have been cut simply by not paying bills? In my experience, such behavior is considered somewhat unethical, dishonest, and might generally result in legal action.

And, third, will the Government publish soon an account of just how much money, if any, is being saved by the present system? After all, the system has been in effect for 8 months. We would also be interested in knowing how much of the present expenditures for health care goes into the system itself and is not spent on care of the sick people.

When these facts are available, we hope the American public will have a choice and be able to decide whether the dollars saved, if there are any dollars saved, are worth it in the terms of the loss of quality of health care and the loss of availability of health care. Certainly, the present system of legislation does not take into account the necessary social, humanitarian, and compassionate aspects of medical care, that are necessary to give good medical care.

Thank you very much, and I signed and dated this the way we have to do everything now in medicine.

Mr. **Jeffords**. Thank you very much, Dr. Butsch. And thank you all for giving us some very graphic demonstrations of some of the fallacies of the present program.

Without at all saying that I necessarily agree with the statement I am making, I would just like to try and put things in perspective as to why we are here. I think you would agree with me that the source of funding for medical care has changed completely over the last 20 years. Until the midsixties, it was almost all paid for at the local level, within the State, or by medical insurers. At that time the Federal Government entered the picture and now is carrying a very substantial share of the burden of health care.

Since then health care costs have been going up at a very substantial rate. Expenditures in the Medicare Program have increased from some 30-some odd billion to some 60-odd billion over the last 4 years. Thus, the Congress became involved, for better or worse, in order to do something about the increase in the cost of health care.

Since the institution of the prospective payment system, health care cost increases have slowed from approximately 16 percent to about 5 percent per year. If you presume that these figures are correct and that without changes, health care costs would have continued to rise at the higher rate, then this difference means a savings of $6 billion a year.

The question we then have to face as policymaker at the national level, is whether the problems which you have outlined very graphically, are so numerous and of such severity that we should junk the cost-containment policy, the PRO's, the DRG's and go back and try some other reform policy? Or, is it a question of refining and improving the present program so that we can continue to try and bring health care costs under control and, yet, no longer do so at the expense of creating inhumane situations as you have outlined.

So, my question to you would be, keeping these things in mind and the problems we face in bringing the $200 billion deficit under control, is the system that we have created here so bad that it ought to be junked or is it a question of figuring out how to work better with the PRO's and the DRG's so that we make sure that these problems do not occur? Would it be better, for instance, to turn health care over to the States with some sort of a block grant program and get the Federal Government out of it, awarding funds through a system of anticipated health care due to the demographics of the population? Or, just what would you recommend at this time?

Dr. **Ferry**. Well, I had another part in this presentation that I did not include. And I think maybe that now I should. Because to me the biggest single problem that faces medicine today is that of the threat of a nuclear holocaust. We know that one, that a thermal nuclear explosion took place over Hiroshima 40 years ago. And we know that at that time thousands upon thousands of people were killed: men, women, children, some soldiers. We know that 90 percent of all the medical facilities and 90 percent of the doctors were destroyed at that time. And we further know that from our testing of our nuclear devices at the Bikini Atoll in 1954 that 9 years after this, the natives who had been evacuated from their homes were no longer able to return inspite of the removal of 2 inches of topsoil and reforestration.

Twenty-two years later the natives could go back but only if 50 percent of their produce was imported. And, yet, we continue to spend our tax dollars on weapons that we can never use and that we as physicians recognize that there is no possible medical response to their use and that contamination of the soil, the water, and this atmosphere. And, so, in my answer to your question I would bring forward the thought of reallocation of funds and I would further bring forward the thought that we must realize that we must move beyond war.

Mr. **Jeffords**. Thank you, Doctor. I certainly believe we all would hope that would be the situation and I would agree that were it not for the huge defense budget, we would have more resources to allocate and I appreciate those comments. I wish it were that situation that we would face. Thank you.

Dr. Butsch?

Dr. **Butsch**. I would like to say that I do not think you need to junk the system, but I hope that some of the inequities we have pointed up can be changed. So, in other words, on the outpatient list, they are not going to be listed as necessary, they would just be listed as "may."

On the reviewing, there have got to be changes so that the reviewer of the reviewer of the physician does not have such power. How we change that, I am not sure. As you know, those physicians are being paid at a good clip for their reviewing. I think you have to show us that the price you are paying for the review is worth it.

You can call $5 or $6 billion worth of savings, but if that is savings because you have not paid bills, like Mr. Shatney's bill or the other lady I mentioned or other bills I would be glad to bring up, that is spurious savings.

Mr. **Jeffords**. Thank you, Dr. Butsch.

Dr. Reynolds?

Dr. **Reynolds**. I think that a system that has been created is probably worth saving because I think in the long run it will cut exorbitant health care costs which I think are a very real problem. It does cost a lot to live twice your normal life expectancy.

I think that the Government, through its nonpayment of bills, is a very dangerous precedent to set because if the taxpayers do not want to pay their bills, we are not afforded that privilege, yet. We have to pay our bills, but you do not. And it sort of sets up a double standard. And I think it is very dangerous that the Government teaches that it is profitable not to pay a bill.

Mr. JEFFORDS. Thank you.

Dr. Burns.

Dr. BURNS. Well, I think the main problem there is not necessarily to junk the system. I think the main problem there is to get the PRO in closer contact with us. Instead of taking a big club—waiver of liability and sanctions and threatening us with a problem, that they get together with us and bring this to the conference table—an olive branch and not a big club, and perhaps we could get together and try to solve a lot of these problems.

Mr. JEFFORDS. Thank you.

Congressman Hertel?

Mr. HERTEL. Well, Dr. Ferry, I am glad you did speak on the issue of priorities. Doubled the defense budget with nothing to show for it as far as progress toward a better peace in this world, and, yet, we are putting the burden on the people that need the assistance more and more.

In fact, this afternoon, I am going to have to leave the hearing early because I am heading a task force on defense, waste, abuse and fraud. And we are going to be on the defense bill this week, later this week and next week in the House. And, so, the Speaker's office called me this morning because of some new developments regarding the budget.

But let me just say relative to the system and what you have all described today. I mentioned before, I am from Detroit. And when I was in college, I worked for a time at an auto dealer's. And they had a book similar to this looseleaf that we have here and if you turned to page 15, or whatever, they would tell you how much you were paid to fix, how much time it would take, and how much the mechanic would be paid, for fixing a carburetor or whatever else it was. You are describing that our system is like that, too, except for the very important difference that people are not cars. People are individuals and there cannot be a perfect formula written for the amount of time it takes or the amount of assistance someone needs for individual people. And you have done an excellent job, I think, of describing that problem. And what you are saying is that the system needs to be more flexible and more compassionate. And I thank you for your help.

Mr. JEFFORDS. Congressman Blaz?

Mr. BLAZ. Thank you very much, Mr. Chairman. I do not have a question, but I do have a comment. And that is that I am so used to hearing patients lament on the system, but this is the first time I have heard physicians show the concern and the courage to appear publicly to express their reservations. And I think I owe you gentlemen a salute because quite frankly I had not realized that the system had placed you in such a position where you are so much concerned about costs and figures and bargain sales rather than administering medicine. And for a profession as noble as yours to be put in this ridiculous circumstance is a very compelling case to take a look at the system, again.

With respect to the comment on Defense, it may be obvious to you, now, I am a product of the Defense system of the United States. I am a retired military type.

Just the other day, just yesterday, I was mentioning to Congressman Hertel how differently the view looks from where I sit now.

And while at one time I may have been a very, very strong supporter for practically everything that we needed in Defense, it is amazing how differently it looks from a rest home, from a hospital and from a State like Vermont and from a territory like Guam.

I congratulate you for your courage and for your very, very appealing presentation this morning. And to the extent that I can be of help in getting something done, I promise you that I will.

Mr. **Jeffords**. Thank you and thank you all for your excellent and important testimony. And I would agree with Ben Blaz that you are certainly to be commended for taking the time out of your busy days to come and share your experiences with us in the hopes of improving a system which is in obvious need of improvement if we are going to make it an acceptable one for our society.

Our next panel is Sue Salmon, a former employee of mine, who has gone on to bigger and better things and doing an excellent job in the health care area, and Gary Marcotte. Sue Salmon is with the Beverly Manor Convalescent Home in Rutland and Gary Marcotte, the Vermont Nursing Homes in Barton.

Incidentally, while we are waiting for the panel to get ready, I'd like to announce that we will be working through lunch. We will be taking a moment or two to run out and grab something to eat so that we will be able to maintain our concentration through the afternoon, but we will keep right on going as all of us have deadlines for leaving the hearing. Congressman Hertel has been called back to Washington because there will be an important announcement from the White House and he will be asked to critique it as it relates to the Defense Department. And I have to leave the country as the congressional observer at the International Labor Conference. And I know Mr. Blaz has to get back to Washington as well. So, we will try to maintain a tight time schedule. We did get slightly behind but I expect that we will be able to come close to the proper adjournment time.

And, Sue, it is always a pleasure to have you with us and I know that you are a very articulate spokesman for the areas that are of major concern and will have solutions to some to the problems we have been investigating.

Ms. **Salmon**. Would not that be wonderful?

Mr. **Jeffords**. Yes.

Ms. **Salmon**. I am going to pass to Gary to start.

Mr. **Jeffords**. Gary, all right, you can go right ahead.

PANEL THREE, CONSISTING OF GARY MARCOTTE, NURSING HOME ADMINISTRATOR, BARTON, VT; SUE SALMON, NURSING HOME ADMINISTRATOR, RUTLAND, VT

STATEMENT OF GARY MARCOTTE

Mr. **Marcotte**. Thank you. Congressmen, my name is Gary Marcotte. I am a registered nurse and the owner/administrator of Maple Lane Nursing Home in Barton. I am an active member and immediate past president of the Vermont Health Care Association which represents 30 of Vermont's nursing homes. We are cognizant of your interest in this arena, Congressmen, and appreciative of your efforts on behalf of the elderly.

Although I recognize that the GAO, AARP, and the National Coalition of Nursing Home Ombudsman have expressed their concern that DRG's are having a negative impact on the elderly who are suspected of being prematurely discharged from hospitals, I have not seen this happen at our nursing home nor have I heard widespread disgruntlement by my Vermont peers.

I am assuming that we are not seeing preemptive DRG discharges to nursing homes for a few reasons: There is a constant backlog of hospital patients waiting for nursing home admissions. Vermont hospitals are nonprofit which means they tend to be responsive to community needs; and with Vermont ruralness, local accountability remains a positive incentive to appropriate service.

We in the nursing home field have seen generally an increasingly more difficult patient to care for, but I feel that has been a steady phenomena instituted by the Government's utilization review program and by the industry's ability and desire to meet the challenge, as well as the effectiveness of the community based services.

I have been encouraged to make a few remarks or observations as to the state of the long-term health care delivery system. It is interesting that even in our small State no fewer than six regulatory, legislative, industry, and consumer groups are convening special task groups this summer to study our delivery system in Vermont and how it continues to be impacted by Washington.

A recent article neatly encapsulated the primary paradox of nursing home policy. No one seems to like nursing homes very much, but there is a widespread perception that we do not have nearly enough of them.

National demographics note a 200-percent increase in our population since 1900 while the over-65 population has exponentially exploded at an 800-percent increase since that date.

The average resident in Vermont's nursing home is close to 83 years old, with a medical profile of three to five chronic debilitating and deteriorating diagnoses, and a social profile of no supportive family and no money. I am disheartened that well-intentioned advocates continue to push for policies to "keep people out of nursing homes." As an industry we realize that any insitution is not a substitute for home and good health, but this old lament only makes our job more difficult in providing care to fragile, anxious, elderly that first feel that the reason society wants to "keep them out of nursing homes" is because they are horrible places and, second, that they have failed society by ending up in one.

Our professional staff is supposed to take this societal-produced, anxiety-laden individual and restore him/her as soon as possible to our alternative delivery system.

Unfortunately, we, as a society, prefer to take an ostrich view and fail to recognize that there is no cost-effective alternative for a person appropriately requiring 24-hour professional health care. We, as providers, so-called servants to this segment of the population, foolishly fail to recognize that we are talking about many segments and thereby varying needs for the chronically ill elderly. Yes, we need a strong community-based system of services; but, also, yes, we need cost-effective methods to provide round-the-clock services for those individuals that are not capable of having a quality of life with only community-based services.

Unfortunately, because both community based and institutionally-based services are largely tax supported, we are divided into our camps to fight for inadequate dollars to fully and appropriately fund all recognizable and reasonable needs.

My summary of this issue is that we need to strengthen the scope and depth of both bases of services.

The biggest problem with nursing homes is they look attractive to physicians and clients when it comes to need satisfaction. We have physical therapy, restorative nursing, therapeutic diets, transportation. All one-stop shopping and a single bill.

The community-based services, each agency provides excellent quality services for what they do, but the gaps coupled with the duplication or limitations make the word "system" a joke. However, the problem or fault is not theirs.

I brought with me today a chart that is loaned to me from the Office on Aging that really kind of illustrates this problem. These are major Federal funding for a long-term period that comes into Vermont. On the left-hand side is the different funding sources such as Medicaid, Medicare, social services block grants. On the right-hand side are the community services that provide such services as skilled health care, home health, medical equipment, chores, meals, transportation, and so forth. And, as you can see by the colored lines, they are varied and sundry, but, unfortunately some large gaps in there in a lot of areas where you cannot get the services under one administration. And, yet, if you go to two sometimes the catch-22 is you cannot have both. It makes it frustrating for us when we are trying to discharge somebody back into the community.

Even in a small State like Vermont each department is given a responsibility for a piece of the long-term care action. This is pathetically true, also, on the Federal scene. Would it not make good business sense to assume that data collection, communication processes, regulatory analysis and implementation, utilization, review and other related processes could be much improved if all parties were in the same room?

The multiplexity and multifaceted issues of long-term care in general could be more efficiently addressed, policywise, by a department charged with a single mission. I am not suggesting an added agency, but reorganization of the already existing players. And my prediction is that the avoidance of duplication and savings of dollars would be well worth the effort. The status quo is not always the most effective or efficient option.

Another area that deserves attention is the underutilization of nursing homes. A nursing home, according to Representative Claude Pepper, quote, represents the greatest concentration of personnel trained in caring for the elderly, bringing together as they do the various disciplines of medicine, nursing, pharmacy, social work and physical, occupational and respiratory therapy, end quote.

I would also add, a building geared to serve the elderly. A kitchen which is only utilized three times a day, and administrative capabilities able to direct and manage a broader scope of activities in the long-term care than we have done traditionally. Adult day care, respite services, hospice and even limited home health and homemaker services have been tried in some States, and it makes good sense that our industry should be encouraged and challenged, nationwide, to expand our role beyond the doors of institutional care.

One of the most exciting bright lights on the horizon to help us avoid a complete run on State and Federal coffers in meeting the needs of the growing elderly population is long-term care insurance. A study commissioned by the Department of Health and Human Services indicates that a large share of Medicaid expenditures, up to one-quarter of projected outlays, could be saved if more older Americans insured against the risks of nursing home and long-term care services. A significant obstacle to the growth of private long-term care insurance is the lack of consumer awareness as to the limitations of their coverage under Medicare. Most Americans assume that public programs will provide necessary coverage. Others are misled into believing their "Medigap" insurance provides long-term coverage.

During the past year, two major barriers have been overcome in developing private long-term care insurance: the advent of actuarially sound policies and the establishment of affordable premiums. Just this month, Aetna, a major insurer, announced a long-term care policy which will be offered in all 50 States. Data on the income and resources of older Americans suggests that long-term care insurance is within the means of most senior citizens. The challenge is to stimulate effective marketing of this new product. Several policy actions need to be considered in stimulating market development, including taxation incentives in the Federal and State revenue laws to encourage individuals and families to purchase private long-term care insurance; revision of insurance regulations, facilitating market expansion; increased public education regarding limits of Medicare and of supplemental insurance policies; and, coordination of public and private financing initiatives to assure adequate protection for all consumers of long-term care.

In closing, let me say that the members of the Vermont Health Care Association applaud the purposes of this hearing and the other committee and task force studies which are examining the status of long-term care. In the simplest of terms, it is an intricate and complex issue.

I did bring also with me today something that has been recently published as of the end of last month by our national affiliate. It is called, trends and strategies in long-term care. And I did leave a supply of them out there on the table which I find is quite excellent.

And thank you for the invitation to appear before you today.

STATEMENT OF SUE SALMON

Ms. SALMON. In 1976, I had 98 Medicare beds. This morning, I had 4 Medicare patients and 1 skilled patient under Vermont State regulations.

My advice to any family admitting an elderly relative is there is not truly a Medicare Program in the United States. What has happened is although the program was developed over a number of years, starting I think in 1976, the regional offices of HHS developed their own interpretations of the law. If you live in California and fracture your hip, you can stay in the nursing home until you walk 60 feet. If you fracture your hip in the State of Vermont, 10 to 15 feet is sufficient before your Medicare coverage is denied.

To my knowledge and 12 years of experience in long-term care, I have had approximately 10 patients receive 100 days of Medicare. All the pamphlets and information that the Government puts out states very clearly to the elderly that they have 100 days of coverage and that is a fallacy. And unfair to the public.

I will not be redundant. I know lunch is coming. I think Gary did a marvelous job representing it.

Mr. JEFFORDS. The adult population, in Vermont is a relatively low-income population. The figures I have indicate that the income—this is in 1979, so, I presume it has at least improved somewhat—was about $11,000 a year for persons and families and around $5,000 a year for unrelated people living alone. Would it be feasible for people at these income levels to afford the kind of premiums you are talking about for private insurance?

Mr. MARCOTTE. My understanding, Congressman, is that the policies are basically marketed for about $30 to $60 a month on a capitation per day basis toward their nursing home care up to maybe $50 or $60 per day of coverage. That basically would go for about 4 years. And they are varied. There are about 25 companies right now that are offering a whole bunch of alphabet soups of coverage; but about $30 to $60 a month for the premium I would not think would be out of bounds for the amount of coverage that you would get.

Mr. JEFFORDS. I still wonder when you are talking in terms of a $100 a week income, with the amount of rent and expenses people must pay, if it would be feasible. I do hope you are right. I think there is some hope in the new types of premiums which will be offered; but I would like to point out that it is certainly not going to be easy. And it may even take some sort of subsidization in order for the majority of our people in Vermont to be able to afford coverage. Thank you.

Also, I wonder if both of you could comment on the situation which we hear is becoming a significant problem, at least, if not a serious one; where patients who were discharged from hospitals enter nursing homes and then need to be readmitted. I wondered if you, in your experiences, have had any significant or serious problem with people needing to be readmitted after being discharged from hospitals under the DRG's.

Ms. SALMON. We have not experienced any increase in our admissions of returning to the hospital. And, again, because we are a skilled and intermediate care facility, we have a much higher level of professional staff. The physician that spoke earlier indicated that the woman had been discharged to a level III. In that type of facility in our State, they only have a nursing overview. In other words, a nurse may only come in 4 hours a week to review medications. And, basically, I think she probably was discharged to the wrong level of care. She should have gone into at least an intermediate care setting.

Mr. JEFFORDS. Gary?

Mr. MARCOTTE. We have not experienced any problem in that area, Congressman Jeffords, as far as readmissions are concerned.

Mr. JEFFORDS. Thank you.

Congressman Blaz?

Mr. BLAZ. I do not have any questions, Mr. Chairman. What I had you have already asked.

Mr. JEFFORDS. Thank you very much.

Ms. SALMON. Thank you for inviting us.

Mr. JEFFORDS. We deeply appreciate your testimony.

Our next panel is Peter Cobb, Vermont Home Health Assembly, Montpelier. Joan Blankinship, The Caledonia Home Health Agency. Eileen Blake, The Waterbury Public Health Association, and Sarah Thompson of the Visiting Nurses Association. Please come forward.

Peter, as soon as you are ready, please proceed.

PANEL FOUR, CONSISTING OF PETER COBB, EXECUTIVE DIRECTOR, VERMONT ASSEMBLY OF HOME HEALTH AGENCIES, MONTPELIER, VT; JOAN BLANKINSHIP, CALEDONIA HOME HEALTH CARE AGENCY, ST. JOHNSBURY, VT; EILEEN BLAKE, WATERBURY PUBLIC HEALTH ASSOCIATION, WATERBURY, VT; SARAH THOMPSON, VISITING NURSES ASSOCIATION, BURLINGTON, VT

STATEMENT OF PETER COBB

Mr. COBB. Thank you for the opportunity to present concerns of home health. I will not spend your time going over the list that I have presented to you, for lack of better words, a laundry list of specific proposals in Congress that we would like you to consider and take our list back with you, and hopefully if you have any questions come back to me or to any home health agency or to any home health agency in your district.

I do want to make two comments on the list or on the testimony that was given this morning. Earlier, Joel Cook, the director of the Vermont Office on Aging, mentioned one problem in home care is the definition of homebound. And surprisingly, on my list I did not have that; but he is totally correct. The definition and the restrictive definition of home bound is a problem with home care. And I will give you an example.

In order to be eligible for home care services, you must be technically homebound. If a woman, say, an 86-year old woman and if her daughter takes her twice a week to a senior center, picks her up and puts her in the car, brings her to the senior center where she sits and plays cards or whatever and picks her up in the evening and takes her home, she, technically, could not be considered homebound. Those types of requirements, I think, are a mistake.

What I would hope that you would do is to contact Vermont Medicaid. Homebound is not a requirement under Vermont Medicaid and I believe it is working well and I would think that the Medicaid officials could tell you that.

Basically, I am going to refer the rest to the three directors of the Home Health agencies to give more specifics.

Mr. JEFFORDS. Thank you.

Joan?

[The prepared statement of Mr. Cobb follows:]

SUMMARY OF VAHHA POSITIONS ON KEY LEGISLATIVE ISSUES

1. Intermittent care: In order to qualify for Medicare home care benefits, a patient must be in need of "intermittent" as opposed to daily 24-hour care. This rule makes no sense especially with the hospital prospective payment plan now in effect. Patients are being discharged from hospitals more quickly and sicker than ever before with greater burdens falling on the home health industry. The DRG system has not only increased the need for daily care but also added patients to the home health roles who need more than one visit per day.

Rep. Henry Waxman (D.-Ca.) has introduced H.R. 2371 which would allow Medicare coverage for home health services on a daily basis. VAHHA strongly supports this bill.

2. Waiver of liability: On February 12, 1985 the Health Care Financing Administration (HCFA) published its proposed rule to eliminate the Waiver of Liability protection for home health, hospital and skilled nursing facilities. According to the proposal, hospitals and home health agencies would lose their presumptive waivers beginning October 1, 1985. The waiver serves as a safety net for both providers and beneficiaries. Eliminating it would force agencies to refuse services to some clients who need and qualify for care. Few agencies can afford to serve clients for whom they may not get paid. In addition, interpreting Medicare rules on a day-to-day basis is as much art as science. Some decisions made in good faith will inevitably be considered wrong by Medicare auditors.

3. Revenue sharing: Federal Revenue Sharing is crucially important to Vermont's 20 home health agencies. At present, town funds make up some six percent (6%) of the agencies' income in the state. Eliminating Revenue Sharing would surely dry up town money available to home health. This money is especially important because it pays for those services not adequately funded by other sources.

4. Liberalization of "skilled nursing" in home health benefit: Congress has gone on record in favor of changing the priority of government spending which favors placing Medicare and Medicaid patients in institutions. Despite progress that has been made towards encouragement of home care, the primary impediment to the delivery of home health services is a restrictive definition of "skilled nursing".

As a result of the general definition of skilled nursing in the law, fiscal intermediaries are applying varying and restrictive definitions, much as with "intermittent care". Some FIs are saying "skilled nursing" means "hands-on" care only and are denying any evaluation or assessment visits. Some are saying if more than one visit a day is needed, then the care is not skilled care because institutional care is needed. Others are defining specific activities which HHAs believe require nurses as those which either a home health aid, relative, or family member could do. And other FIs are defining persons as "chronically unstable" and therefore not eligible for skilled nursing care because more than "intermittent skilled nursing care" is needed.

VAHHA believes that it shoud be government policy to take care of the aged and infirm first in their own homes where possible and only as a last resort should they be placed in long-term care facilities. VAHHA supports the liberalization of the term "skilled nursing" which currently limits the number of Medicare beneficiaries who can qualify for home care under Medicare.

5. Expansion of homemaker—home health aide, respite service: The demands for the "less skilled" services of Homemaker, Home Health Aide, and Respite Care, are far exceeding the dollars available. Medicare pays for Home Health Aides only in conjunction with "skilled nursing." Unfortunately, some clients who do not need the services of a registered nurse require the services of the aide. In addition, Medicare refuses to fund homemaker or respite services at all. In Vermont, the State Health Department has one a yeoman's effort funding homemakers but the state alone cannot meet the need.

Homemaker home health aides and respite workers are lower cost services which lessen the need for more technical, higher cost service.

6. Fiscal intermediary: The Health Care Financing Administration is cutting the number of Fiscal Intermediaries which serve the home health industry from the current 69 to 10. The VAHHA has several concerns about this move.

The bottom line is that we do not want any home health agency to suffer as a result of problems caused by the switch from Blue Cross of New Hampshire/Vermont to whichever FI is chosen. We fear that prompt payments to home health agencies are not possible during the transition year from seven fiscal intermediaries in our region to one. Most home health agencies run tight operations with little or no excess cash. Payment delays of three or four weeks would seriously hurt those agencies' abilities to deliver the best care possible.

We feel there are five potential problems which must be addressed in order to assure a smooth transition.

1. Processing Time, Cash Flow—We want 95% of the claims processed in 7-10 days. In addition, no payments should be delayed during the year-long transition due to problems at the new F.I.

2. Claims Review—No agency should be asked to submit documents more than once.

3. Access—

a. An 800 access number is needed.

b. There should be an ombudsman to act as trouble shooter in the region.

4. Protocol—We want written policies for the behavior of the FBI and want them to cite which regulation is the basis for a rejection.

5. Staff Qualifications—Review nurses should have some home care experiences.

7. Hospice rates: The final Medicare hospice regulations published rates lower than those proposed in the earlier Notice of Proposed Rulemaking, making it impossible for many hospices to operate. VAHHA supports H.R. 5141 which raises the payment levels for hospice care.

8. Medicare coinsurance for durable medical equipment: The Senate Budget Committee Report accompanying the proposed Omnibus Reconciliation Act of 1983 (S. 2060) contains a proposal to change the Medicare law to require that senior citizens pay a 20 percent coinsurance on canes and wheelchairs and other durable medical equipment provided to them by home health agencies. VAHHA opposes this proposal.

9. HCFA circumvents regulatory process. Over the past three years HCFA has undertaken a number of regulatory actions which VAHHA feels ignored the regulatory process as required by the Federal Administrative Procedures Act. HCFA has issued manual guidelines and presented written and verbal policy directives which made significant changes in the rules of the game without seeking comment. In addition, when comments have been considered, those affected have had little time in which to respond.

VAHHA feels HCFA should not be allowed to use manual directives or policy changes to make substantive changes in the Medicare program. Leave the policy decision making to Congress.

10. Home and community based services for the Elderly Act of 1985: On May 21, Senator Orrin Hatch along with Senators Edward Kennedy, Bill Bradley and Robert Stafford introduced S. 1181, the "Home and Community Based Service for the Elderly Act of 1985". This bill would establish a block grant to provide funds for states to:

Coordinate all community and home health services currently provided through a myriad of local, state and national government programs;

Identify ways of assisting elderly individuals or groups at risk of institutionalization in order for them to stay at home and in their communities;

Provide basic home and community services determined necessary to keep those at risk of institutional care in their homes.

The VAHHA supports this legislation.

11. Medicare cost caps: On May 14, 1985 the Health Care Financing Administration (HCFA) issued a proposed notice in the Federal Register which calls for a new method for calculating the maximum level of Medicare reimbursement for home health care services. This new approach to the "cost limits" represents a radical departure from the current method of establishing limits on home care reimbursement rates.

Currently, HCFA aggregates the total agency service costs, and a per visit reimbursement limit is set at the 75th percentile of overall national costs. No agency is reimbursed for expenses it incurs over the 75th percentile cap. The new proposal will eliminate this aggregation of services approach. In its place, HCFA would use a method which would evaluate each service individually (such as physical therapy, nursing, home health aides, etc.) and set the cost limits at 120% of the mean of visit costs as opposed to agency service costs.

Under the proposed regulations, if a home health agency is over the cap in one discipline it will be unable to offset this loss by being under caps in other disciplines. Usually a home health agency exceeds a cost cap for reasons beyond its control (shortage of therapists, unusually large number of high cost patients). Cost caps by discipline will no doubt result in the denial of service to some Medicare beneficiaries as agencies will be forced to cut service to high cost patients. VAHHA opposes these regulations.

STATEMENT OF JOAN BLANKINSHIP

Ms. **Blankinship**. Thank you. Joan Blankinship, director of Caledonia Home Health Care Agency in St. Johnsbury, VT, the maple syrup capital of the world.

Our agency serves 25 towns, 30,000 people. The density of population is about 27 people to every square mile. We are very rural. Our income is, per capita, under $8,000 per head.

The agency I serve has a full range of home care services, has a hospice, does homemaker services and some preventive and health education programs.

First, I want to just mention the impacts of the DRG's on our agency. Yes; we are getting folks sicker, quicker. It did not happen when our hospital converted in October 1983. About 9 months later we began to see an increase in the volume of our business and much sicker folks coming out. We have had to gear up to respond to that.

Let me describe a couple of cases that concern us that we have taken care of, because if the trends we are seeing continue, we might be getting into a problem.

For example, we took care of a lady, 73 years old, who lived alone. She had been hospitalized with a heart attack in October. She was rehospitalized, discharged, and then rehospitalized with an acute gallbladder attack in November and at that point it was discovered she had diabetes, which was not in too good of control. They did gallbladder surgery on her and she was discharged on December 12 and stayed home until the 27th. Now, during that period of time we were working with her and with her distant family to make sure she got the care she needed.

We became concerned because we did not feel she was thriving and discussed this with a physician, but could not get the patient rehospitalized. The family at this point took over and got another physician and this lady was hospitalized in another hospital and found to have, that she was in acute cardiac failure with pneumonia and she died about 1 month later.

Now, 2 years ago, that patient would have been hospitalized the minute we said, "We think there is a problem, here."

Another case that we have seen was an 82-year-old gal, a lady, again, living alone. She had a mastectomy for cancer and she was sent home 3 days after she had surgery with a hemovac and no real instructions as to how to take care of it.

She really needed to have live-in help. She was too frail to be alone. What we did was patch in whatever services we could. We had homemakers twice a day, aides going in. We got some volunteers to go in at other hours. And we were able to help her cope with this. And she came through it successfully.

Our concern is if these kinds of cases and especially this last one keep increasing, the resources of our agency are not going to be able to meet the need. We have got to look in the community to see what additional services we need.

Before I describe specifically the impact or what the changes that have come about in our agency, I would like to just make a comment about Faire Edwards' comments re the home care and high technology that, to my knowledge, all agencies in Vermont are indeed gearing up for high-technology nursing and are doing it and I do not think any of them would allow a dangerously cold IV to be administered to somebody at home.

Also, in terms of—I have had a good time being here this morning. Dr. Butsch's remark about the barium enema, I could not help but want to pick up on that because our agency has frequent referrals for the preparation for barium enemas and we do respond and do that for people: Go in the night before or the morning of. And Medicare does not pay for it. And I would hope, now, I would like to call this to your attention to solve that problem, will you pay us for doing that? One-shot visits, we do not get paid for.

Anyway, to go on about the impact on our agency, we have had to gear up. We have two nurses on the weekends, now. Our visits have gone up by about 10 percent. We have a 24-hour call system that has gotten much more sophisticated. We provide aides and homemakers evenings and nights. We are much more available than we were 2 years ago. We have to.

We have spent a great deal of time and effort and money this year in staff education in terms of high-technology nursing and do find, even out here in rural northern Vermont, we are doing parental feedings or assisting with them and the interal feedings, the IV's at home, including IV pushes and help with dialysis, complicated dressings, the whole span is coming to the rural area and we are running like mad to catch up with it to be able to provide a quality system.

What is needed and how can you help? I think that we are seeing and our concern is that the focus on DRG's is on a medical focus. Our agency looks at people in a wholistic way. And the DRG's are limiting it in terms of the medical aspect of the care and, indeed, DRG's ought to be expanded to look at some of the social issues attendant to people going home. And, if they are living alone and they are terribly frail, et cetera, that ought to be considered.

I think the thing we would like to have most is respite care for people coming out of the hospital: Live-in respite care. I think we could spin a much bigger and better thread if we had that.

I think that all communities have to gear up, now, to the coordinated care. I have heard about problems in discharge planning and people not being ready. That has to be expanded. We have a basis for long-term care coordination in our community. We are now expanding it to try to do a prehospital admission/posthospital admission to run people through that system so we can draw together the network of services needed.

I think it is a model that could be looked at and, as a matter of fact, it has spread throughout Vermont and is worthy of note.

I think the biggest thing, somebody—and I would say the home care system can do it—needs to educate people to help themselves. The home health system does educate individual patients, groups of patients and is uniquely qualified to do this. People should know when they go to the doctor's office and the physician says, "Madam, you need a gallbladder taken out and the surgery," that that is going to mean that she is going to come home in 3 or 4 days post-surgery and the planning at the start, at that instant. And, probably, that woman should be referred to the community resource teams that can do coordinated planning right then. We have got to push it back and do it sooner.

I have, just in ending, would like to say that the report that just came out on the Subcommittee on Health and Long Term Care for the Select Committee on Aging in the House of Representatives entitled, "Building a Long Term Care Policy, Home Care Data and Implications," has four —excuse me, nine very salient points that I wish you would pay attention to. In the interest of time, I will not read them all. You have access to that report, but may I suggest that that would be a good basis for expanding services in the community.

Mr. **Jeffords**. Thank you very much.

Eileen.

STATEMENT OF EILEEN BLAKE

Ms. **Blake**. My name is Eileen Blake and I am the director of the Waterbury Public Health Association, one of the Medicare certified home health agencies in the State, located here in central Vermont.

I also do discharge planning and coordinating between my agency and the Central Vermont Hospital. For the most part, the DRG system has been beneficial to my agency and the patients we serve.

In the 8 years I have done coordinating with the local hospital, I have noticed that most people are anxious to go home from the hospital and return to family and friends to finish their recuperation at home with our assistance, skilled nursing services and therapy, such as physical therapy, occupational and speech therapy.

We anticipated a greater demand for skilled nursing with the DRG system and instituted a 24-hour answering service and 7-day-a-week care. We have seen our skilled nursing visits increase 50 percent over the past year. To date, the referrals we have received from physicians and the hospital in the area have been medically appropriate for our services. We have had very little difficulty with our documentation and that of the patients' doctors' documentation readmitting patients to the hospital when their medical condition changed and hospitalization was medically necessary.

We do not, however, see all patients who go home with continuing care needs. The Home Health Agency and discharge planning in general is dependent upon obtaining signed approval from physicians to follow patients at home. Most physicians refer their patients to us very appropriately; however, a few seem reluctant to share their patients with other health professionals, despite the pressures of the DRG system. We think we can be more help to physicians and to patients in this area.

The problems we have seen with the DRG system is the lack of recognition of the social problems many people have to cope with and the lack of resources in the hospital or community to assist these people. These people, mostly elderly, who will not need 24-hour skilled medical care do need 24-hour supervision and assistance with activities of daily living, often on a short-term basis.

Prior to the DRG system, this usually occurred in the hospital. An example would be a 90-year-old woman who lived alone and falls and bruises her hip. She goes by ambulance to the hospital and has an x ray. It shows no fracture and she has no identifiable medical instability except she is having difficulty walking and the stress of the situation has caused some increased confusion. A few days in a nursing home would provide the meals and assistance for the ambulation she needs, but usually there is a waiting list for beds and nursing homes are not anxious to take short-term admissions due to the paperwork requirements.

The patient may also be adamant about not going to a nursing home, fearful of not returning home, or of the social stigma many people have regarding nursing homes. The community alternatives are also difficult if the patient has no family or no willing family to stay with her. The Home Health Agency can provide a few hours of homemaker service per day, some physical therapy and the Office of Aging can provide some prepared meals; but, due to poor ambulation and confusion, she needs 24-hour care. Our short-term live-in assistance program would meet her needs, but funding is minimal through the independence fund, and personnel who live in for room and board and less than minimum wage is scarce.

Other examples we have seen in the Waterbury area of DRG problems are elderly mentally ill patients living in boarding homes who develop medical problems, are then hospitalized. Their medical problems become stable or chronic and a higher level of care beyond boarding home is needed. This person also has developed an increase in behavior problems during hospitalization. The patient is medically ready to leave the hospital but cannot return to the boarding home and the nursing homes refuse to accept him due to behavior problems. Home Health is also not appropriate as the patient has no family support in the community and long term care needs are apparent.

Some needs I believe should be addressed are as follows: education of the public as to what hospitals, nursing homes and community based health care programs provide. With patients coming home quicker and sicker, funds to care for them have not always followed and have been threatened over the past couple of years. We feel Medicare needs to liberalize their restrictions on daily care visit limits regarding home health.

The Home Health agencies have depended on community funds, usually from Federal revenue sharing funds, to cover the cost of patients without insurance or for those costs not covered by insurance, for those not able to pay. Loss of these funds would be very harmful.

And the funding for programs such as homemakers, respite care, live-in companions, which have helped people remain in their homes is very limited. Many agencies have waiting lists for these services and are still feeling the pressure by shorter hospitalizations to provide the service post-hospitalization.

There needs to be some study of the nursing home situations so that the people who are unable to remain in their homes, especially due to lack of family support, or inability of family to cope with a patient's mental status have timely access to nursing homes.

Thank you for the opportunity to speak.

Mr. **Jeffords**. Thank you very much.
Sarah.

STATEMENT OF SARAH THOMPSON

Ms. **Thompson**. I represent the Visiting Nurse Association of Burlington as the director of the Hospice and Home Care Program. Our agency offers service to residents of Chittenden and Grand Isle counties, an area covering 800 square miles and roughly one-quarter of the population of Vermont.

I want to spend the next several minutes speaking about Hospice, which is one of the more, I think, positive programs that exists in the current, somewhat depressing health care climate.

We have offered a Hospice program since October 1980 when we, together with four other Vermont agencies, were selected to be one of 26 sites in the country to participate in the Federal demonstration covering hospice care.

As you know, an outgrowth of that demonstration was passage of Federal legislation implemented in October 1983 that made Hospice service a part of the regular Medicare Program. There are now five Medicare certified Hospice programs in Vermont covering the northern part of the State and offering the benefit to terminally ill Vermonters and their families.

Our program, alone, has served over 400 clients and families.

We feel that the hospice benefit links in a very important way to the DRG reimbursement system in that hospice programs offer the potential for early hospital discharge or prevention of admission for those clients and families who choose home care for management of a terminal illness.

I would add that we feel strongly that this must be a choice. Hospice needs to fit philosophically for the patient and family and a support system must be in place to provide ongoing care. Hospice does not replace family member care, but rather supports their efforts and offers appropriate periods of respite.

In addition, the bringing together of home based professional expertise with community volunteers insures a cost saving to the system, one of the goals of the DRG plan. Given the cost savings associated with hospice and the quality of life potential to clients and families, we ask your support of H. R. 2070 which is a bill that extends the hospice benefit beyond the 1986 Sunset clause now built into the current law. Unfortunately, the Health Care Financing Administration will not have by that time the needed data to make a decision on continuation of this benefit. While we are not completely happy with the many regulations associated with this, in fact, we would like to see several of them changed, we do think it would be a terrible loss to terminally ill clients and their families if this service could not be offered.

In the hope of sharing in some small way the impact of this program on families, I would like to close with the following letter sent to us by one of our hospice families:

> None of us wants to think about the inevitable death of our parents, and yet this loss touches everyone sooner or later. In recalling my father-in-law's death, it arrived as death often does, far too prematurely.
>
> Upon hearing Poppi's illness was terminal, I distinctly remember the interminable, deafening echo of that word. Prior to that horrible moment I rested so much

hope in the stories of friends' relatives who had been diagnosed similarly years ago and had somehow beaten the odds.

Doctors are less likely today to predict how long a patient will live, but when backed in a corner, they did tell us that he would not see the New Year. Eventually, Poppi overcame the shock and devastation of being told he was dying, and chose to meet life's final challenge head-on. So, it began, our saga of caring for Poppi at home.

Weeks passed filled with hundreds of phone calls requesting and dispensing information, arranging for home care/comfort items: a hospital bed, walker, shower seat and safety grab bars; several overnight visits to the Medical Center Hospital of Vermont, daily trips to the radiation department for weeks of treatments, grappling with the frustration of returned meal trays and the feeling of helplessness in witnessing a loved one's physical deterioration.

Many times upon returning home after spending the week-end with Nanny and Poppi, friends would ask, "How do you do it?" And I would think about how they were facing each day with such hope, optimism, and determination and how I drew strength from them.

Before long, however, it became increasingly apparent to us that Nanny needed more help than we were able to provide, and it was Poppi who initiated the call to the Visiting Nurse Association. Our family was extremely fortunate to have sought and promptly received the invaluable support of the VNA, which later included their arranging for three marvelous caring volunteers from the Chittenden Hospice Organization.

It was this combination of professional service, coupled with the support of many caring friends and neighbors, that allowed us to care for Poppi at home—the one place besides work where he was most comfortable.

The hospice movement truly is a unique life-fulfilling organization that I am most grateful to have known. I applaud the unselfish, unique contributions made by hospice volunteers around the world, and encourage other families to seek their support.

Now that Poppi has completed his life with us on earth, we can be proud of our final gift to him, and find peace in the knowledge that his spirit is at rest with God.

A warm and generous man, he too left us with one final priceless gift: a deep understanding that people enrich our lives not only in life, but also in death.

Mr. JEFFORDS. Thank you very much. And thank you all.

I think you represent what all of us hope will be an improving and more available service, both from a cost-cutting perspective, but, more importantly, in order to help individuals enjoy their lives and the remaining years of their lives.

I would like to ask you what problems you see on the horizon, for your service due to the increased demand created by the DRG system. There are some things on the horizon, like proposals to reduce revenue sharing that you mentioned which would perhaps cut back significantly or substantially on your ability to provide services. I would like to ask your opinion of this, first of all, Eileen. It concerns me, knowing how important revenue sharing is to many of our communities in Vermont, that this program is on the chopping block and there does not seem to be much enthusiasm for continuing the program.

I would like to ask, No. 1, what impact this cut would have on the availability of home health care. No. 2, there is another recommendation which I am sure you are aware of, and that is a proposal for copayments for home visits in the Medicare Program. And, again, taking into consideration the demographics of Vermont's elderly, I would like to know what your feelings would be on such a program change.

So, whoever wants to start is welcome to comment.

Mr. COBB. The question of revenue sharing, I suppose I can answer that as well as anyone. In Vermont, revenue sharing and its relation to home health is crucially important. At present, the average home health income from the town, not necessarily from revenue sharing, but from what the town has given it, runs around 6 percent of their total budget. The significance of the 6 percent is even greater than the numbers because for the most part it covers services that no one else will cover.

They may use the money for home health aides where there is no other funding and that type of thing. Important services that no one else will cover.

If revenue sharing is to stop, and it appears it may, that will make a significant impact on the ability of towns then to give money to the home health agencies. In Vermont, it is very important, the town moneys, to the services provided. I cannot speak honestly for the rest of the country, but certainly from our point of view revenue sharing is crucially important to continue.

Mr. **Jeffords**. Anyone else like to comment?

Ms. **Thompson**. Just about 50 percent of our town allocation comes through revenue sharing. The towns chose to put our budget in that Federal budget.

Mr. **Jeffords**. What percentage did you say?

Ms. **Thompson**. About 50 percent of our town revenues are in Federal revenue sharing. We started out in a regular town budget, but over time as Federal revenue sharing became available, they moved it to that category. And, so, if revenue sharing disappears, I think it is going to be really difficult for towns to find the money to replace our allocation. And that money is used for people who do not have insurance and who cannot afford to pay for the service. We are nonprofit voluntary agencies and offer our services regardless of one's ability to pay.

Ms. **Blankinship**. It is really for the near poor, non-Medicaid eligible population.

Mr. **Jeffords**. What about the possibility of copayments for Medicare home health care?

Ms. **Blankinship**. Well, my concern with that is not only that where we are with the low average income that would be difficult for people to take out of pocket and pay; but, secondly, to administer that copayment and collect it is going to increase the cost of the home care agency. And I wonder if that increased cost is not as much of a problem as the revenue you are going to get from the copayments, at least where we are.

Mr. **Jeffords**. I will agree with that. Can you give me a better idea of where your funding comes from now and what percentages are from each of the various programs?

Mr. **Cobb**. 40 percent comes from Medicare, about 20 percent from Medicaid, private insurance is I think about 30. I am not sure.

Do you know what private insurance is?

Ms. **Blankinship**. About 10 percent.

Mr. **Cobb**. 10 percent and then the rest is sort of other, town funds, et cetera.

Ms. **Thompson**. United Way.

Mr. **Cobb**. Or donations, United Way, grants.

Ms. **Blankinship**. Contributions.

Mr. **Cobb**. 60 percent, basically, would be Medicare/Medicaid combined, on the average.

Mr. **Jeffords**. Now, as the number of visits you make goes up and demands continue to grow, what is your ability to handle this increasing load?

Ms. **Thompson**. I think as was mentioned before, most home health agencies are gearing up to deal with the sicker patients who are coming out of the hospital more quickly. The dilemma is that the resources, the reimbursements from Medicare has not shifted to the community. So, we still struggle with the intermittent definition, with the homebound definition which limits what we can do and be reimbursed for.

Mr. **Jeffords**. I, too, am disturbed by some of the definitions that we have to react to and find them very counterproductive particularly when you reward the families that perhaps abandon their senior citizens and penalize those that want to give help and care to them. It just does not seem like a very wise system. I agree with you on that.

Congressman Hertel?

Mr. **Hertel**. I would just thank the people and commend them for their advice and for all the good they are doing.

Mr. **Jeffords**. I want to thank you all. I think we will take a break at this point, due to the fact that, thanks to this panel, that we are back on schedule.

We will take a 15-minute break, but we will start a little bit earlier than the schedule at as close to 12:30 as we can.

Thank you.

[Whereupon, a short recess was taken.]

Mr. **Jeffords**. The Subcommittee on Retirement Income and Employment hearing will resume.

Our next panel is Dr. William Tisdale, gerontology department, University of Vermont; and Dr. Carl Runge, gerontology department, University of Vermont; Dr. Felix Callan, a general physician from Berlin, VT.

If you would come forward and join us at the table, please.

PANEL FIVE, CONSISTING OF DR. FELIX CALLAN, BERLIN, VT; DR. WILLIAM TISDALE, DEPARTMENT OF GERONTOLOGY, UNIVERSITY OF VERMONT MEDICAL HOSPITAL, BURLINGTON, VT; DR. CARL RUNGE, GERONTOLOGY EXPERT, UNIVERSITY OF VERMONT MEDICAL HOSPITAL, BURLINGTON, VT

STATEMENT OF DR. FELIX CALLAN

Dr. **Callan**. I am just going to be brief because most of the things that need to be said are obviously going to be said by those more versed in the information on the subject.

But I have one hot button and that is something that affects the elderly because eventually it will diminish their care at the local hospital. And that's the designation of Central Vermont Hospital, for instance, as a rural hospital rather than an urban hospital.

And I have done a little bit of research on this with the Vermont Hospital Association and the New Hampshire Hospital Association and become aware of the limitations on an urban and rural hospital designation. And I know we don't have a large population base here, but we have 60,000, 65,000, 70,000 people who are using the Central Vermont Hospital. And that hospital has people referred to it from areas from the Connecticut River to Bolton and from Randolph to Hardwick and on north. And that is a significant referral area in central Vermont.

A rural referral designation has also been inserted into the designation for hospitals and indeed, in New Hampshire, two hospitals, the Mary Hitchcock Clinic and the Cheshire Hospital in Keene have been designated as rural centers. And that makes a significant difference as far as a hospital is concerned. Because, then, under the DRG's they get reimbursed on urban compensation rates, not rural compensation rates.

And in my own field of orthopedic surgery, Central Vermont Hospital loses $1,000 to $1,500 on every total hip replacement, every hip replacement, that the three orthopedic surgeons there that do them carry out.

We do the same surgery that is done at the Mary Hitchcock and the same surgery that is done at Burlington but the hospital loses money on it.

The Mary Hitchcock and Burlington get a significant increased allotment to the hospital for covering the care of that elderly person.

What I'd like to ask you, Mr. Jeffords, is to help us.

Your office help us in changing Central Vermont's designation from a rural hospital, which is inappropriate, based on its referral pattern, to a rural center similar to Mary Hitchcock and Cheshire Hospital in New Hampshire. And I believe Rutland and Bennington Hospital in Vermont.

I realize that designation requires a certain case mix, a certain case load. It requires a minimum number of discharges in a given year. But I think we can satisfy those requirements, and with any Federal program that imposes an injustice on one area, there can be such things as waivers of fine technical detail in that application for a rural referral center.

Mr. **Jeffords**. Doctor, if I may ask you, is there any hospital to the north and east of you that has a definite rural referral center?

Dr. **Callan**. There is none. There is no designation in Vermont at present except, I believe, talking to the Medicare Blue Cross people this morning, Dan O'Neal mentioned there are just two in Vermont, and that is Rutland and the Southwest Medical Center in Bennington.

Mr. **Jeffords**. Thank you very much. We'd be happy to work with you and see what we can do.

Dr. **Callan**. Thank you.

Mr. **Jeffords**. Thank you.

Dr. Tisdale.

STATEMENT OF DR. WILLIAM TISDALE

Dr. **Tisdale**. Mr. Jeffords, Mr. Blaz, thank you very much for this opportunity to meet with you and to comment on some critical problems relating to long-term care of the elderly.

As you know, Dr. Runge and I are members of the gerontology unit in the department of medicine in the University of Vermont College of Medicine. In this role we work with students, resident physicians, practicing physicians throughout the State in providing care for older people, studying the problems of long-term care, and teaching the practices and principles of geriatric medicine.

This rather unique academic role in the State's only medical school has let us recognize some real and potential problems in the structure of long-term care, especially as it applies to older people.

What we would like to do briefly is to mention two general issues which I'll describe, and then Dr. Runge will address several specific issues which relate to long-term care.

First, integration and coordinating of long-term care services are often inadequate, often grossly inadequate. As you've heard throughout the morning, many individual services programs and facilities are active and effective, there's no doubt about that.

As you look around, most acutely ill older people are admitted properly and promptly to general hospitals. After discharge, the majority of older people do receive the required rehabilitative nursing care in nursing homes. With proper planning and a lot of orchestration by health home help agencies, most of these older patients can return to safe and supportive home environments.

But this lateral movement with respect to long-term care is frequently erratic, slow, demoralizing for everyone involved. At the one end, free admission screening, the responsibility of the PSRO, has been in place for only 6 months. But most elderly patients, as you study the record, are really not affected by this review.

Its mandate to date is related more to cost containment than the quality of care of older people. At the acute hospital care level, we know that Medicare DRG regulations have reduced the number of elderly patients admitted and the length of stay, but the program still operates in near isolation. Denial of Medicare payments to patients in community hospitals may have a very serious domino-like effect on the next step in care, and certainly in the next episode of illness of these patients.

Then, arranging transfer from hospital to nursing home care is often frustrating for everyone involved. State-regulated nursing homes, State-financed Medicaid programs and Federal Medicare programs combined to create an administrative interface that is simply incomprehensible to most patients and to most physicians.

Social workers and administrators somehow sort out the rules and resources and arrange for a transfer of elderly patients, many of whom, as you know, are still quite ill but have waited for weeks in the hospital. As the nursing home stay passes the 3-month point, Medicare benefits end and the search for private funding begins or the spend-down of the Medicaid begins.

The fortunate patient in the nursing home who leaves for home often requires a lot of very intensive planning by home health agency members and key people from the agency on aging. That's still another thing to look at in the continuing of long-term care.

So my message is in this first point, is neither profound or original, but my point here is despite the best efforts of a wide range of agencies and individuals, coordination of long-term care is still inadequate; it's unpredictable, and it's demanding. Each element in the long-term care chain or spectrum seems to have a special mandate, a special funding service, and a special sense of self.

Ill and dependent older people simply can't fight their way up and down this ladder, even with expert guidance, becoming lost along the way, they are placed in inappropriate institutions or levels of care. So my first plea is for better integration and more effective patient advocacy.

My second concern is concerned with the quality of care. By definition erratic or piecemeal medical care is poor care. So the first problem goes directly to this one on quality of care.

In addition, we're concerned that much of the recent Medicare and Medicaid legislation and regulations gives only lipservice to the quality of care received by older people. The major emphasis in all these laws and regulations is on planning utility and costs. PRO does look at propriety of procedures, utilization and quality assurance committees and hospitals do screen for gross clinical inadequacies, patient care groups and nursing homes do review obvious problems and home health agencies and professional practice committees which do set and maintain standards.

But which patient oriented authority seeks to define assess and assist upon high quality professional care along the entire spectrum of long-term care. To my knowledge, there are no statements of special health care needs for the older person to guide most providers of health care systems, most of whom are attuned to acute inpatient care.

Predictably, there are very few protocols that take into account the characteristics of older people. If you look at the DRG classification, at best, it's a very gross descriptive clustering of diagnoses with very little consideration made for age and its effects. Very few quality-control committees really look at the basic elements of geriatric care: Diet, safety with medications, need for exercise, skin care, and the like.

Rather, they tend to ask questions about catastrophic events that may occur within, such as coronary thrombosis or stroke. The Medicaid regulations dictate the duration and level of nursing home care but you see nothing there about patient wishes and worries, concepts of functional health and the importance of precise prognosis.

You could argue that the administrative and regulative parts of this work are really the job of the senior staff of each component in this long-term care spectrum, and personal care ought to be kept at an individual level. This may be slow, but I think you'll agree that many of the regulatory financial concerns are so demanding and so consuming of these organizations, that they overshadow and displace personal care concerns.

In conclusion, direct, sincere, and continuing concern about the quality of care provided each person at each level of care is a very real index of a successful health care program. Those committed to improving and revising our patchwork of long-term care services for the elderly should make this concept an absolutely essential one.

There must be a clear, authoritative, and ongoing quality of care commitment expressed along with the commitment to efficiency, economy and simplicity. The quality of care, I admit, is among the most difficult issues in long-term clinical medicine, but that's certainly no reason to neglect or to minimize it.

Thank you very much.

Mr. JEFFORDS. Thank you, Doctor. Doctor Runge.

STATEMENT OF DR. CARL RUNGE

Dr. RUNGE. Congressman Jeffords, Congressman Blaz, we appreciate the opportunity to present our views on the health care needs of the older population. Your visit to Vermont today is particularly welcome at a time when we are recognizing tremendous growth in the older population and an increasing difficulty at all levels of society in meeting the needs of our elderly.

I would like to make—most of my comments today will be of a rather specific nature, and a rather programmatic nature. I would like to make a couple of comments about nursing home care, and then spend most of my allotted time in addressing some of the health care needs of the community dwelling elderly.

One major problem with nursing home care is the necessity for an older couple to pauperize themselves so that one may receive the needed care. The problem is described with great clarity in an article that appeared in Newsweek on September 27, 1982. The problem that was described here in 1982 really hasn't changed since then. It's still there.

To solve this problem, I think we must look for ways to insure ourselves against long-term care problems, as we insure ourselves for acute medical care. Another problem that we have with nursing home care is the inconsistent application of the regulations that govern eligibility for level 1 care by the medicare intermediaries. We run into the problem of a different reviewer on different occasions who will interpret the regulations differently so that a problem that it seems would be eligible for level 1 care and is so, on one day, may not be eligible on other days.

We see that as a problem.

To move onto community care concerns, I would like to first address community care homes or level 3 care homes as they are termed in this State anyway.

These provide a nursing overview less intense than nursing homes and offer an alternative to nursing home care for the somewhat less disabled. The problems that we see with community care homes are as follows:

Level 3 community care homes are really available only to the well-to-do. The cost in our area for community care homes ranges from $430 a month to $650 a month. These were costs that were current as of last year, and refer to community homes in the Chittenden County area. These costs are subsidized by no private and no public programs, with the exception of SSI. The catch is that most level 3 homes do not accept the SSI level of payment for these services and therefore do not accept SSI clients.

Of the five community care homes in Chittenden County for example, one does. One is partially subsidized by the Catholic diocese so that they do accept SSI clients, but the rest of them do not. Once again, a solution here would be some form of long-term care insurance that would provide for this type of care.

The second problem with community care homes is that they have a tendency to shy away from physically able but cognitively impaired elders. Now, the latter is a growing segment of our population that is particularly ill served by our society's programs. And I'll address a little bit more about that in a few minutes.

Moving on to community service, what do we envision as needed in terms of community service? One thing that I'm sure you've heard a lot about today—and I wasn't here for the morning testimony, but I'm sure you've already heard a lot about the need for increased support for visiting nurses' services.

With the DRG's in place over the last year and a half, people are being discharged from the hospital sicker and needing more intensive nursing care once they are home, and I would simply at this point like to lend our increasing support for visiting nurses services. They do a marvelous job, and they could do better if they had greater resources.

One way to reduce the need for the more expensive forms of professional care is to look for ways to help family care givers. How can we do this? Well, there are a number of approaches that we might take to support family home care givers. And I'm going to speak to these under the categories of helping the disabled to become more able, first.

Second, training family care givers, and third, providing respite for family care givers. When we talk about helping the disabled to become more able, we're talking about rehabilitation, and there are a number of things that we could do to improve our ability to provide outpatient or community rehabilitation.

One thing we could do would be to liberalize the rather strict medicare regulations that govern reimbursement for outpatient rehabilitation by physical therapists, occupational therapists, and speech therapists. Their hands are really kind of tied in terms of providing only limited amounts of rehabilitation under the Medicare Program.

Another thing that we could do would be to encourage the development of day hospitals. This is a concept that is growing in England and in Canada, and there are a few in the United States. There are about 10 States that have enabling legislation for day hospitals. And what I mean by day hospitals is a facility and a program that provides outpatient day nursing and rehabilitation services designed to improve physical capability and living skills largely with people with physical handicaps that are at least to some extent remediable.

Another thing that we could do in helping the disabled become more able is encourage the development of day hospitals geared for the Alzheimer's patient or the cognitively impaired patient. Such centers would provide cognitive training and, again, training in living skills for this particular segment of the population, which is a segment that's growing very rapidly.

Another approach to helping the care givers is the training of family care givers, training them in the resources and skills that they need to provide more skilled care toward the family members living at home. This can be done through community education training programs. We've had at least one such program that I know of in Chittenden County last fall which I think was very effective in providing some of the training that family care givers need.

Another way of doing it is that if you had day hospitals or Alzheimer's day hospitals, one of the services that you would provide would be counseling and training for the family as part of the overall program.

A third way to help family care givers, is to provide programs that provide them a little respite, the point being that if a family care giver can get a break from 24-hour care, 7 days a week, ad infinitum, that they might be more likely to maintain a family member at home for a longer period of time.

And there are a number of ways that we can provide respite. One is to encourage the development of adult day care centers. These are a little different from day hospitals which have a more rehabilitative goal. The adult day centers provide 3- to 5-day-per-week day care socialization and recreation for older and handicapped individuals.

Such day centers can be geared to physically handicapped or cognitively handicapped clients. And what they do in terms of respite is that they allow the family care giver to work during the day. It's just like a day care center for children, where it allows the mother to work, this allows the family care giver to work during the day. And the older person is cared for during that time.

Now, other approaches to providing respite to family care givers are to provide easier access for grid placement in long term care facilities and community care homes or nursing homes. In other words, if a family knew that every 6 months, they could schedule a family member into a community care home or a nursing home for 1 week so that they could have 1 week's vacation, that would go a long way toward easing the burden of their care.

Also, unscheduled admissions, for example, when the family care giver gets sick and needs some care him or herself, if you had easy access to a community care home or a nursing home during that period of time, that would again facilitate care giving at home. The alternative to this is to have a community service, perhaps, from the visiting nurse service that would provide short term inhome care givers under these circumstances.

Those are a few ways that we can help family care givers.

The final suggestion that I would like to make in terms of community needs, addresses a small but significant part of our older population, they are the older people who have no family, who live alone, and who are becoming disabled, and again, incompetent to manage their own affairs. This segment of the population needs guardians and those of us who work in long-term care, finding guardians is a very hard thing to do.

We need to encourage the development of community pools of guardians to provide training and support for people who would serve as guardians and to enlist the whole court system in this endeavor to facilitate the guardianship or the legal facilitation of guardianship would help a great deal.

So, in summary, we're seeing an ever increasing need to care for and support a growing number of older people who are becoming physically disabled and/or cognitively impaired. In particular, the latter, the cognitively impaired group represent a rapidly growing segment of our population for whom community institutional resources are especially inadequate at the present time.

We don't really look for the Federal Government to solve all our problems for us. But I think that we, as a society, need to really work together closely on the community level, on the State level, and on the Federal level, to develop a well-coordinated, long-term-care system which insures that all of us maintain our capabilities for as long as possible and receive the care we need when we become disabled.

Thank you very much for the opportunity, Congressman Jeffords.

Mr. **Jeffords**. Thank you very much for some excellent suggestions, suggestions we need very badly. Now it's a question of how to implement them.

Let me ask first of all, Dr. Tisdale, we had some very dramatic testimony earlier today, that you refer to in your statement and that is the problem of someone who comes in with a specific ailment which, when you look on the DRG chart, says, your patient should get *x* amount of care.

And yet that person comes in with the additional problem of malnutrition which isn't sufficient by itself to cause an admission, and yet, when all the factors are taken into consideration it is inadvisable to discharge that patient at time *x*. What can be done with the present system so that those factors can be taken into consideration?

Dr. **Tisdale**. First of all, in most hospitals in Vermont, at any rate, it is taken into consideration and you kind of stand prepared to pay the price. You do what's right and then worry about it later on. DRG's, as you know, are derived in a rather artificial research way, and they don't take into account, probably can't take into account, all dimensions of illness. The individual variations are infinite. So there's no system that's going to ever account for every nuance.

And I think it's that inflexibility that worries me. We act as though we don't care; we do care. We're concerned about cost containment, too.

But in looking at the individual with good conscience, you find that there are an infinity of variations. You have to be flexible; you have to change your plans. So I think it's being taken care of on an individual hospital basis at some expense to everyone, but I think what we're asking for in the future is more flexibility, more judgmental options in caring for very complicated, older people who have a multiplicity of problems.

Mr. **Jeffords**. Of course, looking at it from the other perspective, if you allow a lot of discretion, then it's quite conceivable that we'll end up right back where we started. Everyone is going to want to use their own judgment again, and care will be extended and off we go back to the problem of rapidly increasing health care costs.

Do you think that some sort of balance is possible?

Dr. **Tisdale**. Right, and that's what I think most of us hope for in the next 5 years, is that we'll learn from the DRG experience and we'll see that there are commonalities in care; that age does carry certain risks in terms of hospital care, surgical care, and that those will be taken into account. There will be commonality but there will be more flexibility for individual judgment. And when I say, individual judgment, I mean judgment that can be questioned, challenged, analyzed. Not blind faith judgment, but judgment that you'll defend with your peers.

Mr. **Jeffords**. Carl, comments?

Dr. RUNGE. No, I don't think I have any further comments about that. What comes to mind, as I listen to the conversation here, is that the whole DRG system might have originally been better suited and worked better if it had been applied to nursing homes rather than to hospitals.

In other words, it would be I think somewhat simpler and could be more logical to develop a case mix reimbursement system for nursing homes that would be based upon the functional health and the service needs of the individual in the nursing home rather than specific medical diagnoses. You might reimburse differently for an individual who required all aspects of daily living skills done for them, transfers, eating, toilet and things like that.

That person might generate a higher level of reimbursement than the person who had lesser needs. Or the system could be developed that would be, to me, a little more logically based in that segment than has been done in the hospital segment.

Mr. JEFFORDS. Thank you. You have such a list of very helpful suggestions here, I could spend the rest of the day talking with you. I certainly agree with you, that first of all, we ought to have insurance available that people can, at an early time prior to crisis time, use to protect themselves from ending up in a poorhouse situation.

I also agree with you that, if we had some way to help people caring for a relative get the respite they need to lead somewhat normal lives, then we would probably greatly reduce the social costs since more people would then be willing to take their moms and dads into the household rather than, for whatever reason, casting that responsibility on society.

I wish you would give me an indication of the numbers of day care centers or respite centers in Vermont? Is that something which is actually being experimented with here, or is this just something that's hoped for?

Dr. RUNGE. Well, with regard to day centers, there are a number of—there are at least five adult day centers in the State of Vermont. All of them have been developed on the model of respite, socialization, rather than rehabilitation model. More recently, through the Vermont independence fund, the adult get-up-and-go day center in Burlington has been able to introduce some rehabilitation. They've been able to introduce both physical therapy and occupational therapy in the clients there, in the year since that program has been in existence, has been able to demonstrate a small but significant increase in functional capabilities of the people who participated.

So, we're sort of at the very beginning in the State of Vermont in terms of day services. And it's an area that I feel we really need to develop more.

In terms of respite services of the kind that I described, of short-term admissions, I'm not, it's been talked about, but I'm not aware of any that have been put into practice as yet.

Mr. JEFFORDS. Well, do you have any suggestions as to what we might do to promote the expansion of these services? In other words, would it help if under certain circumstances, a family were able to say, we will take the adult home with us providing that we are able to have some relief, and if reimbursement of some scale were available either for conditional home health care or the cost of the respite?

How would you do it?

Dr. **Runge**. Well, again, it's something that could be developed under a long-term care insurance program. And it would be obviously you know an investment that would be cost saving, compared with the alternative of full-time institutional care. So that would be one way. Another way would be respite care through enabling legislation, through either Federal or State programs.

And the other way is working it out on a private and volunteer basis, although that's certainly not perhaps as reliable as across-the-board, but——

Mr. **Jeffords**. Thank you. Thank you very much, both of you, for your excellent testimony and suggestions. Before I let you go, Congressman Blaz.

Mr. **Blaz**. Let me just ask a quick question. In the administration of the Medicaid Program, perhaps this is something you may not want to comment on just as yet. Various States have different levels of participation; some 60 percent of the cost; some 70. And some provide more care than others.

What is the case in Vermont in terms of the revenue that's shared by the State to match it with Federal funds?

Dr. **Runge**. I don't think I know the answer—I don't know the answer to that.

Dr. **Tisdale**. Roughly 25 percent State, the balance Federal, I think. It's weighed heavy toward the Federal.

Mr. **Blaz**. I see. I know because as I read the literature on this thing, I know it does vary.

Let me also just make a comment. The chairman has brought up a topic that is beginning to have some significance to me. The community where I come from, which is the territory of Guam, does not have hospices; we do not have rest homes; we do not have nursing homes. And as a result of this, the family assumes this responsibility and it is just part of the culture.

Now, I'm not so sure that in the course of time when we discover there are many other opportunities, we might not change this, but it seems to me that his point is well taken that maybe from time to time we ought to have a program, a promotion or an education program whereby we have a very palatable way of saying to the family, hey, you could probably alleviate some of these things if you'd just pick up on this thing yourself a little bit.

I don't, you know, and it's not easy for me to say, because I don't run for office in this State, but the contrast is so marked between my community and other communities throughout the United States. And I know no other community where there is no rest home, there is no nursing home, and people just assume the responsibility for the care of the elders, except for those that require a physician's care.

Dr. **Tisdale**. May I just comment, briefly?

Mr. **Blaz**. Please.

Dr. **Tisdale**. That's true in many societies and I think it tells you a very important fact. A lot of what we think is technical, scientific health care is culturally determined, attitudinally determined. And I think that the thing that amazes me is so many people in this country think we're harsh; that we're unkind to our parents; that we banish people to nursing homes.

I would say Carl would agree with me; it is not the fact. Most families, by the time they admit an older person to a nursing home, have gone through unbelievable self-denial, denied their children support, trying to keep an older person in their home. So, in spite of the fact that our society doesn't look very happily on this multigenerational home, and kind of the sacrifice which I know is real in your country, even though we don't believe that is true. But people do give up a lot, and what we're arguing for I think is that what you're saying is they ought to get more recognition for what they've done, more support for what they want to do but can't.

I don't know whether you'd agree with that but I really am impressed with what people go through, lacking the societal support that you describe.

Mr. **Blaz**. Well, please don't misunderstand me. I'm not condemning anyone; I'm just saying that in my own case right now, in our home in Virginia where we temporarily are living, we have had to take grandma to a nursing home, as a matter of fact, because we've reached that point where the culture no longer takes care of it, but up to that point, it was just so significant to her that we had given so much, and I think her mental attitude was so different, when she finally said gee, listen, I don't think you guys can handle me anymore. I think we're beyond this.

I don't know if I'm making a comment out of line here but I was persuaded by the question by Chairman Jeffords.

Mr. **Jeffords**. No, it's a good point. I think some credit is due to people who don't get recognition for what they've given up in this society, too.

Dr. **Tisdale**. This often happens in our society under our present social policies, and I could give you other examples where we seem to reward essentially the wrong people and—a better way of putting it is, we don't reward those people that go out of their way to take the burden. I'm not saying, necessarily, that those that don't take the burdens are wrong; but some of those that do share in those burdens and are willing to go beyond what is the social norm, ought to be rewarded instead of penalized in the final analysis.

Thank you very much.

Mr. **Jeffords**. I think we're seeing here, as we go through the day, many different aspects of the health care situation, all the way from the recipients of health care to the providers and to a certain extent, those that administer the programs. So, I'm very pleased that we have you with us today.

I see you are armed with charts and bits of useful information so without further adieu, Dr. Holmes, would you like to start?

Dr. **Holmes**. Maureen is first.

Mr. **Jeffords**. Oh, Maureen. All right, go ahead.

Ms. **Tessier**. Thank you, Congressman.

STATEMENT OF MAUREEN TESSIER, R.N., EXECUTIVE DIRECTOR, VERMONT PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Ms. TESSIER. Congressman Jeffords, Congressman Blaz, I am Maureen Tessier, a registered nurse and executive director of the Vermont Professional Standards Review Organization. Vermont PSRO is a physican-based medical review agency under subcontract to the New Hampshire Foundation for Medical Care, which is the peer review organization that monitors the Medicare Program in the States of New Hampshire and Vermont.

On behalf of the Board of Directors of Vermont PSRO, I want to express my appreciation for providing us this opportunity to report on the impact of the DRG system under Medicare and bring you up to date on our implementation of the PSRO Program in Vermont.

As recently as April 17, 1985, the Medicare final regulations governing the PRSO Program were published. These regulations put in place the final regulatory authority, legitimatized the peer review effort, and helped clarify many issues surrounding medical review policies and processes.

The regulations now signal the administration's commitment to a physician-directed medical review program, to help assure proper evaluation of both the appropriateness of admissions to hospitals and the quality of patient care rendered to Medicare patients. As with any program, these complex processes pose definite challenges for implementation of the review requirements in Vermont hospitals.

Vermont PSRO attempted to approach the challenge in a constructive manner, and we have found, on the whole, that Vermont hospitals and physicians have proceeded with, and accepted, the tremendous changes from a fee-for-service system, to a prepayment system, under DRG's, and that all providers have worked at containing costs.

There have been a number of significant changes in statistics that measure the performance of the DRG Program. Both Medicare hospital admissions and length of patient stays, have decreased an average of 6.1 percent from 1983 to 1984. According to data released by the Vermont Hospital Data Council, total patient days were down 11 percent over 1983. Nationally, hospital admissions declined 3.3 percent.

From a statewide perspective, we believe that the Vermont PSRO Program can be credited significantly regarding these changes in patterns of hospital use. Although the PSRO contract in the State of Vermont was not operational until November 1, 1984, Vermont PSRO was conducting a review of all admissions in hospitals when the prospective claimant system became effective in October 1983.

Undoubtedly, the full impact of a national crises system for hospital services will not occur until after the 3-year phase-in period. But, the decline in hospital admission rates in addition to the financial incentives placed on hospitals, give evidence that changes are taking place, and can be attributed to the review of records by the PSRO and feedback to hospitals and physicians.

In Vermont, all responsibilities under PSRO involve many required review functions which project to actual chart review of approximately 35 percent of all Medicare admissions. Programmatic activities include, but are not limited to,

First, preadmission review—and this was discussed briefly this morning; we implemented a preadmission review program on January 2, 1985, in order to encourage a shift from inpatient to outpatient settings for certain appropriate surgical procedures. Vermont PSRO, with input from Vermont hospital surgical staffs—and that is an important point—identified over 200 procedures that could safely be performed on an outpatient basis in Vermont. Thus far, physicians in hospitals have responded well to this requirement and have reduced elective inpatient procedures by a signficant margin.

Second, we review selected DRG's under our objective setting process. We closely review certain DRG's, for example, DRG 243 Medical Backpain; DRG's 182, and 183, Miscellaneous Digestive Disorders; DRG 429, Organic Brain Syndrome. These are three examples of three diagnostic groups that we review very carefully.

The objective setting process under PSRO contracts was intended to identify known areas of misutilization through past experience in monitoring hospital admissions. It was an area that generated much controversy at the national level, in awarding PRO contracts.

Our past experience in the PSRO program had reinforced our belief that although we could analyze patterns of practice, the inexact science of medical review made it difficult to predict the types of cases which one can or cannot avoid over time or in the future. Thus, setting a numerically based utilization and quality objective, was difficult and was based on somewhat subjective or soft data.

We are following the status objectives very closely, and overall, in Vermont, we are meeting these objectives. However, under no circumstances, does the PSRO base medical review decisions on the need to meet numerical targets. We have also been assured by the Health Care Finance of Administration, that these objectives can be revised, based on our experience over time.

A third, very important program area is quality review. In an effort to evaluate whether quality is being compromised under the DRG system, we initially had a survey in January 1985, in conjunction with the Vermont State Medical Society. We requested that Vermont physicians document situations where they felt the application of the HCFA regulations have resulted in hardships to patients and families or presented inappropriate burdens on hospitals. We saw this as a constructive approach to collect data for presentation to various legislative bodies such as yourself.

The response to the survey was limited. Four home health agencies did submit comments, however, outlining their assessment of apparent weaknesses in the payment provisions under Medicare. One commentator stressed that the manner in which patients discharge needs are addressed during hospitalization is often inadequate.

That adequate discharge planning or home health referrals were not ordered early enough in the patients' hospitalization. Occasionally, home health referrals were made on the day of discharge. And in one hospital, a physician order is still required before a social service worker or a discharge planner is allowed to make contact with a patient's family.

As the PSRO for the State, one of our review requirements is to evaluate all of the admissions of medical patients within 7 days to the hospital. Our evaluation indicates that MD consultants to date have seen no evidence of patients being readmitted acutely ill, due to possible premature discharge on the previous admission.

What we are seeing, however, is a trend in a number of hospitals where the patient is discharged with incomplete management of care, only to be readmitted for followup and completion of medical management at a later date. These cases are being taped and reported in narrative to the HCFA regional offices. Therefore, the weakness in the DRG system, seems to lie not with too early discharges, as much as a need for additional resources to provide needed skilled services in the home.

It is evident that Medicare regulations are restrictive in their interpretation of what constitutes acute hospital level care. Patients who require daily care in the home, or at an alternative facility, or have social needs that impact on a spell of illness, do not meet the Medicare interpretation of hospital level care, and thus must be denied Medicare benefits.

If we are to force earlier discharges from hospitals, of patients who still require skilled nursing care, then it is our observation that home health agencies require the capability and the money to provide this level of care in the home.

Fourth, another area in priority is educational. Vermont PSRO has held a number of educational inservice programs for physicians throughout the State over the last year and a half. We have approximately 150 physician consultants who have attended training sessions and serve as physician consultants to the program. These physicians and our physician committee have recently developed a more systematic approach to raise questions where any quality of care issues surface upon medical review.

Our ultimate goal is to expend an equal amount of effort and resources for quality assurance activity, as well as for monitoring of utilization, thus making the application of the regulations more consistent among physicians.

In summary, we would like to make a number of recommendations.

One recommendation would be that future legislation could extend the scope of PRO quality assurance activities in future contract negotiations.

A second recommendation would be a requirement to recruit Medicare recipients to serve on PRO committees and boards. In Vermont, we traditionally have consumer representation comprise a large percent of our board of directors. And we see this as very important.

Third, proposed legislation could also place responsibility for educating Medicare beneficiaries about insurance coverage, utilization review, and quality assurance, and the impact of these decisions on patients and their families.

A final comment is that the DRG system required a massive change for hospitals, and a complex program to implement for Vermont. If physican-directed review organizations are to remain distinct from the competition, we must listen to the providers. We must attempt to achieve a proper balance between the process and procedures governing bureaucratic regulations, yet stress continued vigilance to insure that more cost cutting does not endanger the quality of patient care.

Congressional and administrative planners have made significant strides that are influencing and improving the efficiency of health care delivery. However, while these economic pressures reflect a basic restructuring of the medical care delivery system, these changes must be carefully monitored to ensure that patient care and access to needed services in rural areas are not jeopardized.

Again, thank you for the opportunity to speak and I will be glad to answer any questions.

Mr. **Jeffords**. Thank you very much, for your excellent testimony, and I want to thank you for your earlier letter, which I will make a part of the record, whi~~ch we also deep~~ly appreciated.

Dr. Holmes?

STATEMENT OF DR. FRED HOLMES, PRESIDENT, VERMONT MEDICAL SOCIETY, MONTPELIER, VT

Dr. **Holmes**. Gentlemen, thank you for the opportunity to be here this afternoon.

My name is Fred Holmes, and in spite of the topic, I'm a pediatrician in Fairfax, and president of Vermont State Medical Society, and a member of the executive committee of the PSRO. Before I go any further, I'd like to point out that the scientific basis for current health care is not all bad. And I'm impressed that much of what I see in the hospital these days is dramatically better than it was when I started my practice. And I suspect that some of my surgical conferees could transplant most anything or fix most anything that breaks.

My concern is perhaps that the art of medicine is not all that it should be. A period of frequent unnecessary admissions and unnecessary surgical procedures and laboratory procedures that characterize I think much hospital work, or a good part of hospital work when I started my practice is now going by the boards, as VPSRO and utilization review and continuing medical education for physicians has tidied up this aspect of our business.

I think we all recognize that liberal reimbursement from Medicare and Medicaid and private insurance companies basis of fee-for-service, and I don't think any of us should be surprised by the institution of DRG's. And I would like to suggest in passing that perhaps DRG's are not all that bad.

The first one I'd like to make, and it occurred to me while sitting in the audience, is that if DRG's accomplish nothing else, other than to get us to take a look at the needs of the elderly from a community perspective, it was a very valuable step to take in the first place.

The second thing I'd like to point out is that the physician community has had to respond to DRG's and, as for instance, my son, Christopher, is back at work now, 3 days after a major surgical procedure on his knee, that 2 or 3 years ago would have required 1 week in the hospital and at least 1 month of rehabilitation.

I'd also like to point out that the cost containment benefits are very real. In our own community, where it used to cost $2,200 for cataract removal and infraocular lense placement in an elderly patient, then as an inpatient, the total cost for hospital services is now $1,100, and the patient goes home the same day.

I need to caution you, though, that through the Blue Cross/Blue Shield Utilization Review Committee, we've attempted to pinpoint cost savings for other hospital surgical procedures across the board, these figures are not available, and it's my understanding that much of the outpatient surgical procedure data is a bit fuzzy and the best figure that we could come up with was a 17-percent saving in hospital services in the pilot program down at Rutland Hospital over a 6-month period. But that's very shaky data.

The problem associated with DRG's, as we've probably heard frequently today, are first of all, not truly a denial of care. I can't think of any situations in spite of our committee's efforts through the Vermont State Medical Society, where we can document situations where Vermont physicians have actually denied care to an elderly patient in need. The problem is denial of reimbursement for care.

And I have watched my mother, and I never cease to be amazed by the plight of an elderly person living alone on a fixed income, Medicare for reimbursement, who fractures an arm, has to go to the emergency room for care, is unable to care for herself, but technically doesn't require hospitalization in terms of our own guidelines, if you will.

But is admitted for care for lack of any other support service in the community; gets her arm fixed, and gets the bill as well.

The second problem with DRG's as you've already heard, I'm sure, frequently today, is the problem of earlier discharge of sicker patients to a home or health agency. This is an issue we've heard raised repeatedly through our committee activities at the Vermont State Medical Society. But there are other secondary problems. Decreased utilization of rural community hospitals in our instance has lead to a decrease in our bed census from 140 beds to some 60 beds at St. Albans and frequently less than that.

It puts our hospitals at risk financially, and because of that, the community loses valuable resources that the hospital can no longer afford to provide us. To wit, we've lost our pathologist and we've lost our orthopedic surgeon.

A secondary problem is that the decreased reimbursement or the decreased income, if you will, for Medicare patients either not being paid for or no longer cared for in the hospital, has lead to a dramatic increase in financial pressures on our hospitals, and these hospital financial pressures are then passed on to the patients. And I'm sure that, for instance, if you were to talk to our hospital administrator at St. Albans, you would get a very dramatic, very reasonable representation of the difficulties they have in, for instance, handling patients who have long term outstanding debts. It's a very difficult problem.

My feeling is, however, that DRG's and increasing utilization review, have in reality just made a bad situation worse. There have always been patients who have had difficulty getting care either from physicians or hospitals based on their inability to pay. With the decreased reimbursement for Medicare patients or, if you will, the loss of the Medicare business, this financial problem is worse and the hospital doesn't bite the bullet, the physician doesn't bite the bullet; it's the patient who does.

And, again, it comes back to addressing things like patients who can't pay cash because they have a long-term outstanding bill.

The other interesting paradox is that this is all going on at a time when major employers are pushing for the development of progressively more complex and innovative programs for providing health care for their employees. Referring to HMO's or PPO's or IPA's or whatever you want to call them, in terms of prepaid with or without capitation, more complex third-party reimbursement systems do afford health care for their employees.

The difficulty is that these programs select out by definition mobile, educated, employed, more affluent, if you will, middle portion of our population, so that at a time when the chronically ill, the elderly, and the poor, are if you will, getting dealt out, the other half is getting dealt in. To take that concept a bit further, if you happen to be an employee at IBM, and you are dissatisfied with your health insurance program, you may approach your boss and it becomes a process of negotiation in terms of your reimbursement for your employment.

If you're a Medicare/Medicaid recipient, you have no recourse; you have no way to affect the manner in which your health care is being paid for.

In terms of solutions, I'm afraid I don't have any. I'm sure you've heard many of the problems today. And some of the details, by definition, we need more compassionate criteria for review of hospitalization utilization by Medicare recipients; and for instance, we need to get rid of the 3-day requirement of hospitalization prior to nursing home placement.

Through the Vermont State Medical Society, we have begun our efforts along a different tack. We believe quite strongly there needs to be a development of integrated community services to address some of these long-standing problems which are made now more intense by utilization of DRG's. As a pediatrician, I think we have a very nice analogy; if you are a child in Vermont, there are EPSDRG outreach workers, there are daycares, there are kindergartens, there are nutrition programs, there are special education programs, and perhaps in a simplistic fashion, I would suggest that they parallel these services for the elderly, who are just at the other end of the age spectrum.

We need to develop alternatives for hospital beds. We desperately need more community nursing services, which I'm sure you've heard before today. We need day care centers, nutrition programs, educational programs. All of these must be based upon a coordination between providers in the community, physicians, nurses, dentists, social services, office on aging, to develop a coalition of providers.

And I might, in passing, say that looking over today's agenda, I was disappointed that the President of the Nurses' Association of Vermont wasn't invited to participate.

All of these people must get together to develop a community service plan and then this plan needs to be implemented both locally and at the statewide level. First, to identify the needed services and to put them in place, the second is to provide the needed reimbursement for these services and third, and perhaps most important, that there needs to be a major component for patient education so that their expectations will be more appropriate.

I don't think that many people think about health care the way that we, at this table, do. It's just something that you go looking for when you find out that you have to have it. And if it isn't there the way you thought it was going to be there, then that can be very disappointing.

To address some of these things, the Vermont State Medical Society for the last 9 months, we've been meeting regularly with representatives from Vermont State Nurses' Association, Vermont State Dental Association, and the Coalition of Vermont Elders, and the Association of Retired Persons, and representatives of the Office on Aging, Coalition of Home Health Agencies.

The interesting problem that we first identified was that we didn't know how to talk to each other. Each of us had our own individual interpretation of the way in which this system worked. We think we've crossed that hurdle and our next step was to try and survey membership of AARP to try and determine some of their perceptions of their own health care needs.

Thank you very much.

Mr. JEFFORDS. Thank you, doctor, for your articulate and perceptive statement. We greatly appreciate the time that went into that statement.

Bob?

STATEMENT OF DR. ROBERT VAUTIER, EXECUTIVE DIRECTOR, VERMONT MEDICAL SOCIETY, MONTPELIER, VT

Mr. VAUTIER. Before I get into my prepared remarks, I picked up something this morning in listening, and it's important to keep in mind that patients don't know good care from bad care. And usually, when you put them in these situations, it's the first time they've gone through the process. They have no idea what should or should not be done. They are totally dependent upon the system, as provided. And in that kind of a setting, physicians are the primary advocates for the patients.

And, again, I repeat, you just don't know what good care is because you've never done anything like this before.

I have some notes entitled "Post War Geriatric Boom."

In 25 to 30 years, we will begin the post war geriatric boom, as millions of American citizens who were born after World War II reach their mid-sixties.

It is imperative that we begin to do the planning and experimentation with systems to care for the elderly now, in order to meet that future need.

I believe the most important issue before us is the need to deal with the care of the elderly as a system, and not to manipulate the individual programs without considering how changes affect the overall picture. I have with me a chart which the medical society developed.

This chart shows the location, type of service, source of payment, and the amounts paid for each setting. In the material you have, you've got a smaller version of this so you don't have to figure out what this one is. But, basically, it goes from the hospital down to home health care, and it describes the various services given at different levels and the reimbursement structure—who pays for what.

The overall picture is one of many different competing factors on the State, local, and Federal levels, which leads to confusion on the part of the elderly that must use the programs.

It is increasingly important to balance the various interests of society. In the past, each group represented on the flow chart has lobbied for their own piece of the program, and the legislators have dealt with the groups separately. How effectively they lobbied would determine what kind of reimbursement they would receive.

Traditionally, these services have not been viewed as a system, and when changes were made, no one took into account how they interacted with other parts of the program. It is imperative to create a system of care that allows people to flow up and down the system, depending on their needs. The system should respond to the needs of the elderly, not just the rules, the regulations, and the ability of various providers to lobby.

Currently, the elderly view the system as a one-way street. Once you leave home, you wind up in a nursing home, and then go to the hospital, and then you go to the undertaker. This should not be so. A person should be able to go from their home to an appropriate congregate or community housing center. If they require increased supervision, they should be able to move into a level I or level II nursing home for 6 or 8 months, and then return to their former setting, when they're physically able.

The same should be true of elderly who must be hospitalized.

The current lack of a system for care of the elderly has led to a bottleneck at the community care home and congregate housing level. For over 10 years, now, the physicians of Vermont have been trying to place patients in appropriate settings, only to find that a lack in the availability of that community care slot is binding up the system.

Each level of care should be looked at in terms of its cost and appropriateness. When the cost to society to maintain a person in their home exceeds the cost of congregate housing or community care homes, then the system should encourage them to change settings. It's important to balance the cost to society versus the benefits to the individual. It's also important to balance the expenditures on the various groups of patients in the system. Society's support for the old, the mentally retarded and the disabled, these things should be comparable.

There are many elderly care systems in operation from which we can draw information. There are some communities in Vermont that have elderly programs ranging from independent condominium living all the way to level I nursing home care, in the same location. These settings of care should be encouraged as the time for the increased need will be soon upon us.

We should support and encourage traditional family values, especially the concept that families should care for their own. However, because of multiple divorces, people who have no children, or those who have lost all family members, society will have a substantial number of elderly who will be soley dependent on the government.

Our society needs to meet this challenge without overburdening the next generation.

Expectations of the elderly 25 years from now are likely to be much higher than they are today. Twenty years ago, if you earned $100 a week, you would pay the maximum deduction for Social Security by the end of the year. In 1985, the maximum employer-plus-employee deduction is $5,584. People putting in almost $5,600 a year are probably going to expect a far greater benefit when they retire, than the people in the 1960's who paid a few hundred dollars a year. This is especially true when one compares what a commercial company will pay in monthly retirement, life insurance, and hospital and disability benefits, if you were to pay them a $5,600 premium.

One way of mobilizing assistance for the elderly at a minimum of government expenditure, is to fund coordinators who would work with church groups, rotary clubs, Jaycees, Lions clubs, and other volunteer civic organizations. These community coordinators could make the needs of the elderly known to the community and assist in developing programs to meet those needs.

Consideration should also be given to the concept of centralizing the funding and distribution of services to the elderly. Currently, we have too many departments competing for the tax dollars and the management of our elderly programs. A statewide, centrally managed system, would cut down on duplication of overhead costs, and give better support to the elderly people that they're trying to serve. This change would require restructuring of our current system, but I believe it's well worth the effort.

I think you saw a chart earlier, which had all those. Looked like a Chinese road map. These things are but a few suggestions, but the main points I would like to leave with the committee, are:

First. We need to start now;

Second. We need to address the current bottleneck at the community care level and start some pilot projects and some planning programs that we could test out over the next few years;

Third. We need to encourage the family units to care for their own;

Fourth. Assistance should be given on a private volunteer level to the extent possible; and

Fifth. The bureaucratic systems should be reorganized to assure that we get the most effective results from the expenditure of funds, because society has limitations.

And we need to encourage citizens to plan for their own future. These things need to be done so that we can grow old with some degree of dignity and security.

And I thank you for your time and consideration.

Mr. **Jeffords**. Thank you very much. Again, an excellent statement. Let me ask one question.

We're obviously here for the major purpose of making recommended changes to the appropriate committees with respect to the Medicare Program. I wondered if you could tell me, in view of your experience and observations the statutory changes that you know of that could be made to the DRG and the PRO methodology?

Ms. **Tessier**. I might answer that. I think the executive director of the American Medical Association AMPRO, which is the umbrella organization for PRO's, nationally, in their concern with the impact of prospective payment on the quality of patient care, have recommended some of the things that I also suggested today.

That more money be appropriated so that medical review agencies all over the country can put as much emphasis on evaluating the quality of care given either inappropriate in too early discharges and that we can't compromise in an effort to reduce the Federal deficit. We also have to concentrate in this area. They were very specific, and I think there is proposed legislation in that area.

Mr. **Jeffords**. Thank you. Congressman Blaz?

Mr. **Blaz**. I want to thank you both. I can assure you, though, that if we did neglect the president of the Vermont Nurses' Association, the record will be held open, and we will invite her to make a statement.

Thank you for bringing that to our attention.

Yes, Bob?

Dr. **Vautier**. One of the things, I don't know, in order to kind of ascertain what specific laws you may want to change, is somehow get a group of people together —I don't know how you would do it—but review the system we've got and see where they can take these things apart and put them back together again. You know, just restructure them.

Mr. **Jeffords**. I certainly appreciate that and of course I would like to have that kind of assistance. It's important for us to be able to be specific in our recommendations. Thank you very much.

Our next panel is Pat Barbieri, of the Foster Family Program, central Vermont; Duncan Robb, Social Services, Central Vermont Hospital; Evelyn Doyle, Rutland Visiting Nurses, and Michael Hall of Vermont Legal Aid.

Mr. **Jeffords**. Ms. Barbieri, I understand you have a guest with you, would you identify her at the appropriate time, please?

Ms. **Barbieri**. OK. I'd like to say that my program is entitled "Adult Family Care." Adult foster care is the generic name. And I have with me a host family care giver, Karen Duval, who has been in the program for a while and is taking care of elderly people in her own home.

Mr. **Jeffords**. Fine. Please proceed as you see fit.

PANEL SIX, CONSISTING OF PAT BARBIERI, FOSTER FAMILY PROGRAM, BARRE, VT, ACCOMPANIED BY KAREN DUVAL; DUNCAN ROBB, SOCIAL WORKER, CENTRAL VERMONT HOSPITAL, BARRE, VT; EVELYN DOYLE, DIRECTOR VISITING NURSING ASSOCIATION, RUTLAND, VT; AND MICHAEL HALL, VERMONT SENIOR CITIZENS LAW PROJECT, ST. JOHNSBURY, VT

STATEMENT OF PAT BARBIERI

Ms. **Barbieri**. Foster care for the elderly or disabled, a new choice in long-term care. Foster care for the elderly or disabled is not a new concept. Before the era when formal and informal institutions were built to accommodate the housing and care needs of the elderly or disabled, families met this need in one way or another.

Fluctuations in population growth and changes in family lifestyles in this century have created new demands and concerns for today's society. The advent of increasing longevity and the upcoming retirement of the baby boom generation, will either become a disastrous burden or a unique challenge.

Some States are meeting this challenge by developing formal programs that will coordinate foster care services. Adult foster care offers those which can no longer live alone, an alternative housing option to premature or unnecessary placement in a resident nursing home or other institution. Most families can offer creative, inexpensive and effective personal care system are those who choose to remain as independent as possible, and to retain autonomy over their own lives.

Their first priority is remaining at home, even if this decision is life-threatening. The idea of moving to a foster home may be second best but it is a compromise many are willing to accept rather than enter into less appealing arrangements.

Some people are incapable of adjusting to the regimentation and formal environment of an institution. The anxiety and depression felt at being housed against their wishes, can have a negative impact on the emotional and physical health. It becomes counterproductive to the motive for placing them there.

And, in itself, places the residents at risk. Institutional living requires that the person adapt to the routine expected of all residents rather than having their daily routine changed to meet the individual's expectations. It is an unnatural living condition where people are lumped together because of age or handicap, at least, on a permanent basis.

A host family offers the familiar, multifaceted and intergenerational social structure. Host families and participants who are part of the Adult Care Program are screened carefully for eligibility. Their living habits, hobbies and interests are compared to determine the most compatible arrangements. This is crucial to the success and enjoyment of the relationship.

Training and assistance is offered to the care givers to assure that skills meet the needs of the participants. Staff or community care agencies may also be brought in to assist. If eligible for services from the council on aging, both the host and participant may be visited by advocates, senior companions, and the adult family care coordinator.

Relatives and friends of the participant are encouraged to maintain contact and to continue offering their support. The participant thus enjoys an additional set of human resources, when the friends and relatives of both parties are involved.

The variety and uniqueness of host profiles offer a participant more choices in meeting their individual needs. A host family can be a couple with children, or a single person. Often, a host care giver is also a senior citizen. A participant can decide whether he or she will benefit greater from an intragenerational arrangement or a relationship with a person from the same peer group.

The average payments per month for expenses is $400 or $500, paid to the host by the participant. The arrangement offers economic flexibility for both parties. If a participant needs a higher level of care at first, such as entering a home after hospitalization, reimbursement to the family can decrease in proportion to the rate of recovery. Social Security benefits and SSI payments of around $427, are used by elderly participants to meet their expenses.

The participant, and possibly his or her relatives, often find creative ways to bargain with the host families for the room and board, and personal support. Criteria for matching is comprehensive, using a holistic approach to the participants' requirements.

Emotional and social well-being is as much as focus as physical health, as mentioned earlier. Being able to continue living in a familiar location in the exact or even similar neighborhood that a participant has always lived in, is significant. If a person's main source of entertainment is sitting on a porch watching the busy routine of city life, he or she is not going to be satisfied in the country, watching a field of flowers.

The emphasis of adult foster care is the integration of the participant into the family's lifestyle as if he or she was a related member, sharing both birthday parties and household chores. The participants offer the family members their own special strengths and support. The simple function of peeling potatoes for supper can contribute to the sense of pride and usefulness critical to a person's feelings of self-worth.

Being able to engage in the mundane aspects of everyday life, the link to reality which many of us do not appreciate until it is denied to us. Attention to a participant's unique personhood is an integral part of this arrangement. The one-to-one attraction seems to be as important to the host as it is to the participant.

The personal support often bordering on pampering, is something which is priceless and defiles any one definition. Adult foster care is an innovative and exciting addition to the existing housing and long-term-care options. It is not intended to compete with or disparage facilities that provide their own kind of service system. Freedom of choice is one of the rights we all enjoy.

In our society, the emphasis is on the individual, and the freedom each of us chooses to determine our own destiny. This program reinforces the promise that these rights are inalienable and must not be denied, diluted or preempted because of age or disability.

Mr. **Jeffords**. Thank you, Pat.

Duncan?

Mr. **Robb**. Yes. Before I start with my regular comments,——

Mr. **Jeffords**. Would you move the mike closer to you, please?

Mr. **Robb**. Sure. Before I started with my regular comments, I wanted to comment on something that Dr. Runge had said about how beneficial it might be to have the availability of respite funds to offer a family a break from taking care of an individual at home. And I know in central Vermont, there is such a program.

Through the independence fund, there is grant money to provide just this service, and I really hesitate to mention it here because it's so sensible and it's working so well, that I may be giving it the kiss of death.

Mr. **Jeffords**. Is that funded through Older Americans Act funds or Rehab Act funds?

Mr. **Robb**. No, that's entirely State funds through the independence fund.

Mr. **Jeffords**. Entirely State funds?

Mr. **Robb**. Yes.

Mr. **Jeffords**. Thank you.

STATEMENT OF DUNCAN ROBB

Mr. **Robb**. I've been working in a hospital for 14 or 15 years now, and I've seen really a drastic change in the medical community's attitudes toward hospital care.

There used to be almost a casual or an easy willingness to admit a patient to the hospital and to retain them there. Today, it's quite the opposite and there is a reluctance to either admit or retain a patient without overwhelming medical justification.

I've been aware of and participating in the utilization review procedure for that same amount of time, and I've seen more of a change in attitude in practice in the past year and a half since the advent of DRG's, than in the previous 12 or 13 years. The message certainly has gotten through.

Hospitals are for the sick, the medically sick, and only the medically sick. Now, certainly, to some extent, this has been a healthy change. The hospitals should be for the sick; they shouldn't be used as babysitters or boarding homes, or as a dump site for social problems, and the medical criteria have been established to prevent this.

But what I think that we are witnessing and was expressed earlier, is overkill. The pendulum has swung too far. The world is not perfect, and rigid medical criteria simply can't encompass all the situations that present themselves in our hospitals. There must be flexibility; there must be common sense; there must be a sense of humanity and compassion, and there must be a realization that patients simply aren't medical diagnoses without social concommita.

Further, there must be a realization that simply because Medicare no longer recognizes a particular problem as justification for hospitalization, does not mean that the problem doesn't exist. The problem must still be addressed somehow, somewhere, and the resources must be available to address it. If not in the hospital, somewhere else in the community. It is ridiculous to believe that simply denying payment for hospital services means that the savings are money in the bank.

Some of those savings must be allocated to the community for the development of more cost-effective community-based treatment. The problems can't be made to vanish as easily as can the Medicare funding that used to contribute to their solutions.

And I know there have been a number of examples given today; I'd like to give one more. At the beginning of May, there was a Mrs. A., a 74-year-old lady, who was brought to the emergency room from her rest home, community care home, because she had an episode of extreme agitation and wandering about, disoriented, jabbering, going into other patients' rooms, hyperventilating, at one point becoming unconscious, and causing complete disruption in the rest home.

The rest home owner became very concerned; brought her to the emergency room; the patient herself was aphasic so she was unable to describe herself what was wrong. She had been discharged from the hospital only a week previously, following a 7-day stay for a stroke, and although it was not known whether she was in the midst of a new stroke because of the recentness of that previous admission and because the, and I'll quote the doctor's note, "multiple problems associated with admission, the physician requested instead that she be placed directly into a nursing home from the emergency room." Now, for 6 hours, one of the social workers at the hospital tried to find a nursing home unnsuccessfully, so that the patient could be directly admitted, but there was no room, no beds were available.

And finally, late in the afternoon, when it became obvious that no place was going to be found, the rest home owner refused to consider taking her back, the patient was admitted overnight after signing a statement of financial responsibility which she didn't fully understand anyhow. The next day, a nursing home bed was found, and she was transferred to the nursing home.

However, even with all these extraneous details, Medicare coverage for the hospitalization was denied, despite the uncertainty of the cause of her behavior and the exhaustive efforts that had been made to find some kind of an alternative to hospitalization.

This was only one example of many that we see; in my opinion, the regulations must permit the consideration of social factors, and further the DRG must reflect that some additional time is necessary for social factors. To not do so is, I believe, to deny the world as it is, and is to place doctors and hospitals, and most of all the patients, in a truly untenable position.

I want to, before I close, I just want to commend you and your staff, Congressman Jeffords, on the interest you've shown in this. It's very heartening. In many situations, I've called up members of your staff here in the local office, and have found great support for both individual and program problems, and I certainly want to compliment you on that.

Mr. Jeffords. Thank you very much, Duncan. I certainly share your feelings about my staff. They're a great bunch; they've done a tremendous job, and I'm deeply indebted to them.

Evelyn, it's good to have you here from the good town of Rutland, and we're pleased to see you.

Ms. Doyle. Thank you.

STATEMENT OF EVELYN DOYLE

Ms. Doyle. I appreciate being here. What I would like to speak to, I'm actually director of the Visiting Nurses Association in Rutland and what we are always doing is looking at alternatives, trying to keep people at home.

Two years ago, we applied to the Independence Fund to create a temporary live-in program, and I was pleased to hear Dr. Runge and Dr. Holmes speaking of looking for alternatives for people that need to stay at home.

Well, that was our concern of our professional advisory and our long-term planning committee, so 2 years ago, we did apply to the Independence Fund to create a temporary live-in program. We wanted to initiate that, because, in our needs assessment, we found three areas that we needed to deal with.

No. 1, post-discharge patients needed temporary assistance during recuperation periods on a 24-hour basis, usually from around 7 to 10 days, and sometimes it would be longer.

No. 2, we had family caretakers that needed respite services; they needed to have adequate relief which is essential to prevent total restriction and fatigue.

No. 3, we found that elderly and frail and handicapped that live alone and become ill while they are at home, might be able to stay there if we had a temporary live-in person who could stay with them, and it would prevent them from going into the hospital or into a home.

Therefore, we did create a temporary live-in facility. Now, our objectives of course were to give some choices and alternatives to the elderly people as well as their families. Most people do wish to stay at home when they're sick. However, many times when they are put into the hospital, specifically elderly people that do not have relatives or someone that's caring for them, decisions are made very quickly and many times they are placed into a nursing home.

I find that usually, when they get into a nursing home, many of them do not go home. They end up staying in the nursing home. The program was extremely difficult to administer because of funds. Most people cannot afford to pay for this. Now, with the Independence Fund, we were fortunate we had it, and that ended with 2 years.

Now, we are looking to try to continue the program and find funding. I have gone to our towns, our United Way, and into the community looking for donations. However, we have many other programs in our Visiting Nurses Association which we need these kinds of funds for and therefore I'm having difficulty finding the extent of funding that I need to keep the temporary live-in program going. It is continuing and it will be used for people that can afford to pay, and for a few individuals that we can afford to pay for.

It would seem, from the amount of people that we kept at home, that if the State and Federal Governments looked at this specifically I think under the Medicaid, possibly they could have a waiver or something where it might pay for the temporary live-in.

And I think, basically, that's what I am speaking to. I think that I would like you to look at ways to see if you can come up with alternative ways to pay for home care. I'm seeing that we not only need skilled services, but we need the unskilled services which are not as expensive; however, it does appear that we will have to run them through agencies for quality of care.

The elderly, I think, are very vulnerable and I feel that they do need the assistance, and they do need someone that can oversee the care that they are given.

Thank you.

Mr. **JEFFORDS**. Thank you, Evelyn. Excellent statement, and certainly that's an area that needs further help. I'd like to commend you and all the visiting nurses for the tremendous service you render. We appreciate it very very much.

Michael?

STATEMENT OF MICHAEL HALL

Mr. HALL. My name is Michael Hall. I'm an attorney with the Vermont Senior Citizens' Law Project, and I work out of St. Johnsbury. I come today not nearly so much as an expert on either long-term care or the DRG systems, as many of the witnesses that you've had today, but more as a sounding board for people with whom I have contact, the other attorneys within our project in the five offices throughout the State, and the advocates whom we work very closely with in the various area agencies on aging all over the State.

Since the implementation of the DRG system, we have been watching it very closely and have had an opportunity I think to gauge from a first hand point of view, just what effect it's having on senior citizens in Vermont. In a sense, I feel like I sound a note of dissent from some of the tone that I've heard today, with respect to whether DRG's are working or not.

And I notified your staff of that before I agreed to come. I think that in our basic judgment, the DRG system has not been as bad a development as the press had lead us to believe, or as much as the publicity has indicated. Our judgment has been, in fact, the DRG system has wound up being the punching bag for a number of other deeper faults in the system, and some of which have been talked about today.

One of them of course has to do with the DRG system has exposed what had been a longstanding weakness in both our noninstitutionalization system, in the community, and with our lower level of care system. Not just with respect to the inadequacy of beds, both level II and level III and IV beds in the State of Vermont, but also as was indicated in the panel before last, I think, that the system really has not been adequately equipped for helping people make the transition, either out of the hospital or out of an institution, or from one level of care to another.

And the situation that was described where an individual is discharged from a hospital with little or no advance discharge planning and with a call to home health agency only on the day that the individual is intended to be discharged, is not at all an unusual situation. On the other hand, the DRG system as a whole, we believe, has had a positive effect for patients and for elderly people in Vermont. You've already heard some of the statistics recited by the PRO. Costs in the State of Vermont have not only risen at a slower rate, but have risen at a slower rate than in the Nation as a whole.

Length of stays are down; census is down. I think the problem, however, has been that the emphasis in the DRG system has been unfortunately the Federal level, as was mentioned I think by Duncan, more on cost-reductions, and where it really ought to be cost-containment. The emphasis has been to figure out how we can reduce the amount of money that the Federal Government is spending on Medicare as a whole on a year-by-year basis.

When in fact I think what we ought to be doing is figuring ways in which we can shift our costs maybe within the fixed amount from the acute level of care to the less acute levels where there really are shortages at the present time. And all of the discussions and alternatives which were being suggested today, I think are important so long as we keep in mind that the goal here ought not necessarily be to achieve a net reduction in the cost of the system, but really to try and focus the resources that the Federal and State Governments devote to health care into the areas where they are more necessary.

Another reason why I think the DRG system has been getting a bad rap, is because, as was also pointed out, a lot of things were changing before the DRG regulations were implemented by HCFA. There had been I think longstanding changes in the patterns of practice that part of which were helped along by the increasing use of peer review and utilization review, and part of which had to do just with the change in the demographic I think of the physician population.

There has been a huge population of new young doctors coming into the system who've been schooled differently and whose attitudes as Duncan indicated toward hospitalization toward the use of acute care facilities is drastically different than it was a few years ago.

Utilization review has been I think embraced by that group more readily than it was by the older group of physicians. The result has been that there has been a shift away from acute care and toward more community care and toward more clinical kinds of outpatient care that really preceded the implementation of the DRG's.

In general, we think that that's good. However, we share the concerns of some others, with respect to the particular effects which it has on people here in Vermont, and the rural nature of the facilities which we are served by. In St. Johnsbury and other places like Rockingham and some of the other rural hospitals, those hospitals are inevitably I think being pressed toward becoming more specialized and toward figuring out ways in which they with decreases in their census, ways in which they can continue to operate profitably.

One of the things that that means for them is that they are going to have to get out of the business of being general providers of acute care, and get into the business of trying to provide care in narrower areas that can generate the kinds of money that they need to stay in business. The impact that that has for people who live in the northeast kingdom, though, is that they are going to have to travel further and further distances to receive cardiac care; to receive certain other kinds of specialized medical services. That means that the kinds of care that were formerly offered at St. Johnsbury and Littleton, are now only going to be offered in Burlington or in White River or further away.

And I think that's a real problem that your committee needs to take a look at and needs to figure out some way to address.

I have a couple of other quick suggestions with respect to concrete changes in the law. The swingbed program is, as it's presently designed, is just plainly not meeting the need, at least not in Vermont. As you know, Medicare Program currently provides swingbed funding for hospitals in rural areas where they have less than 50 beds. Even in the State of Vermont, there are not very many hospitals that have less than 50 beds.

And with respect to coming up with—the classic situation which has been described over and over again today, of the individual who is DRG, who has reached their length of stay, who is no longer acutely ill, and who needs to move to a lower level of care, but for whom no bed is immediately available. Of course, in days in the past, those individuals stayed in the facility until a bed could be found in most instances. Today, that's not happening any more.

The best way to deal with that in the short term is to make better use of swing beds, but the way in which the regulations are currently written has effectively foreclosed that option to most hospitals in the State.

The Medicaid waiver program is another thing that a lot of people today have longingly wished were more effective but in fact the State of Vermont has in effect if not affirmatively declined to participate in the Medicaid waiver program. A number of applications have been filed by Senior Citizens Law Project and by the area agencies on aging, over the course of the past 1½ years since the Medicaid waiver program was announced and to my knowledge, none of them have been approved. The State of Vermont has effectively indicated that they do not wish to participate in this program and I think the consequence is for those of us who were hoping that that program was going to make possible increased home-based family care for borderline individuals, has been very disappointing.

Finally, I echo once again the suggestion made by a number of different groups today. That there needs to be some higher degree of flexibility with respect to the rules which are implemented in figuring out these alternative funding programs. The regulations which were promulgated back in April which permitted an increase in State and Federal participation, also on the bottomline required that the percentage of Medicaid—that the cap on Medicaid remain the same.

For nursing homes and hospitals in this State, that effectively precluded them from taking advantage of those regulations, and I suggest that the committee ought to figure out ways in which it can promulgate regulations that would really permit meaningfully taking advantage of them.

Mr. **Jeffords**. Thank you very much, Michael. And thank you all for your excellent testimony.

Theresa, would you like to say anything?

Ms. **Dibbel**. No, I don't think so. I think Pat said it all.

Mr. **Jeffords**. OK, well, I appreciate your participation, and especially the work you've been doing. Thank you very much.

I want to thank the panel.

Congressman Blaz?

[No response.]

Mr. **Jeffords**. Yes, again I'd like to express my appreciation for your very excellent testimony. We're going to move along because our departure time is fast approaching and I'm hopeful that we'll be able to hear the last two panels before Congressman Blaz has to leave.

Our next panel will be Dr. Conrad Herr of the Rutland Regional Medical Center; Duncan Brines, the Vermont Hospital Association, and Vera Ryersbach of the Social Services Medical Center.

Nice to have you here.

Please proceed.

PANEL SEVEN, CONSISTING OF DR. CONRAD HERR, RUTLAND REGIONAL MEDICAL CENTER, RUTLAND, VT: DUNCAN BRINES, VERMONT HOSPITAL ASSOCIATION, MONTPELIER, VT; AND VERA RYERSBACH ON BEHALF OF THERESA TOMASI, DIRECTOR OF SOCIAL SERVICES, MEDICAL CENTER HOSPITAL OF VERMONT, BURLINGTON, VT

STATEMENT OF DR. CONRAD HERR

Dr. HERR. Prior to 1978, I taught school in several different medical schools.

In 1978, I became Medical Director of a PSRO in the Adirondacks in New York, and during that period of time, I realized that I did not know what medicine was any more. There indeed was a large difference between what I understood to be practice and what the old LMD, the local medical doctor, knew or didn't know, how he cared and didn't care.

I was developing programs such as the Neighborhood Health Center Program, sponsored by the Office of Occupational Opportunity.

I didn't really know what was going on, so I decided to go into practice so I could see. It's a terrifying role up there, if you care about people. I do have four problems I would like to address. All of them have been addressed. I am just going to give them another pat on the head.

The first two problems deal with level—I am not used to "1's" and "2's"—skilled nursing level of care, means something to me, so I am going to use "skilled nursing level of care."

I am going to read a statement that was developed by the utilization review committee of Brooklyn, and was forwarded to Margaret Heckler, Secretary of Health and Human Services, and, Congressman, you have a copy of this letter.

"I am writing on behalf"—this is written by Griff Bates, who is our Medical Director in our hospital. It says:

> I am writing on behalf of our Utilization Review Committee, which is very concerned about the following matter:
>
> A Level 1, skilled nursing facility nursing home, will not accept a Medicare patient unless they have had at least a three-day hospitalization, as Medicare will not reimburse the nursing home unless such hospitalization occurs.
>
> However, Medicare will deny admission of a Level 1 if they are admitted to an acute-care hospital. We have the situation where an ill Level 1 patient cannot get into either a hospital or a nursing home. We hope you will change the existing regulation so that this bond can be eliminated.

If the goal of the PRO legislation is to reduce hospitalization, then there should be a mechanism to admit people directly to a level 1 facility, and have that facility be reimbursed.

In addition, we are concerned about the fact that an ill patient will have Medicare payment denied if they are admitted to the hospital because no level 1 ward 2 beds are available in the community.

The patient who is too ill to remain at home has to be admitted to a hospital if all level 1 or 2 beds in the community are filled.

The fact that the hospital gets denied its payment if the patient doesn't meet PRO criteria for acute care does not seem fair.

Perhaps, retrospectively, an admission was felt to be—we felt it was to be acute; it was judged to be level 1 or 2, we could get paid the level 1 or 2 rates.

At any rate, if you could work on this problem, as well as the one in the first paragraph, we would be most appreciative.

Now, Secretary Heckler sent a note on to the appropriate agency to Carolyn Davis, the Administrator of HFCA, and Ms. Davis told us about the possibility of changing the requirement for 3 days admission, which was being considered. We haven't heard anything more about it. We wondered if it is still being considered.

The entitlement for that, according to Carolyn Davis, was section 123 of the Tax Equity and Fiscal Responsibility Act of 1982.

It was now 1985. We still can't do it.

The other two problems that I had mentioned was the totally—let me make an aside. No one would come today. I volunteered because Rick Bates couldn't come. The reason they wouldn't come was because they were sure it would do no good.

One physician related to me the problem in his thinking—it goes something like this:

Why is influenza vaccine excluded from Medicare? It does not take very much smarts to figure out that if you do not vaccinate people a certain number of them will require hospitalization.

But it takes a more sophisticated statistician to realize that of those who are hospitalized a significant number will die; and if they are dead, they don't require any entitlements any more.

And that's what I'm hearing out in the community; when I stepped out of academe, I am hearing this kind of skepticism, bordering on, if you will, paranoia, but it is a paranoia not for themselves, but for their patient.

So, nobody wanted to come. But I wanted to come. I have got a couple of more things I wanted to mention. One thing is an entitlement that does not exist, and it has been mentioned.

And that is the availability of short-term skilled nursing care. When you institutionalize levels of care—a skilled nursing level of care is an institution; it is not a way of taking care of people any more. It is a building. It is a building with an administrator, and sometimes with people that own stock in it.

And one doesn't want to go through the process of admitting somebody and discharging—that's all very expensive. It's easier if you plug them in and run them, not for 2 weeks, not for 1 month—that's expensive, even if you allowed it, they wouldn't do it, because it is too damned expensive; but it is cheaper than going to the hospital.

And my problem with this is my skepticism is that, and anything that isn't now provided won't get provided, because what we are talking about is an unmet need, and there is no way for unmet needs to be met and save a lot of money; we are going to spend money.

But, anyway, I think it is needed. We often twist the arms of families, to take their old folks home. We tell them all the wonderful backup they are going to get from visiting nurses, the wonderful backup they are going to get from the modern woodman that is going to give them a wheelchair, a walker, whatever.

But if something goes wrong, if we overestimate this family's ability to take care of this poor person at home, they've got no out; they've got no out.

That patient arrives in the emergency room and nobody is there to get a history because they are left there. The reason for that is because we didn't give that one more promise, and that was the promise that we would bail them out if they couldn't make it.

Now, that was one of the promises we made at Tufts in Boston, when we had the Home Care Program. Take care of this person; this person is dying, and wants to die at home; take care of them, or we'll give you a 24-hour, around-the-clock, somebody will come—we'll give you, that is, if you can't make it, we'll take the patient back.

We can't promise that anymore. We can't promise that anymore because we have already sent the patient to skilled level nursing care. They are going to try it at home; they are going to come back to the hospital, special skilled nursing.

One more little thing, and this is a relatively parochial problem. It has to do with Vermont regulations. We have some very good community care homes. Of course, the ones I am familiar with are for-profit homes, but they are really being run very, very nicely.

We have some community care homes where people are very practical. I found them to be particularly practical, and pragmatic, and they have a patient who becomes ill, not ill enough to go into a hospital, but so ill that if the investigator comes around and sees that patient in bed, then the care home is going to get criticized for having patients who are too sick in their facility.

And so they are up against it. When someone who presumably is temporarily in bed sick, temporarily—2 months, 3 months in bed sick, they have to get rid of that patient, even if they are willing to care for the patient after the reimbursement level that they are now receiving, they must move that patient out of there.

We are talking about the family, the extended family, keeping the old person at home. This is a substitute for that; and yet we bureaucratically say, well, there is a line here; we have stepped over it, and you are paying.

I think that ought to get addressed.

I did have one thing that maybe Pat Barbieri made me remember—my grandmother, as she aged, said, "Look, if I ever get so old that you need to put me in a nursing home, you put me in a nursing home at the corner of Broad and Market in Newark; I hate cows."

Mr. **Jeffords**. Thank you very much, Doctor.

Duncan, are you there?

STATEMENT OF DUNCAN BRINES

Mr. **Brines**. My name is Duncan Brines. I represent the hospitals in the State of Vermont, and I guess I would like to concentrate at the beginning, anyway, on the impact that DRG's have had on hospitals, hospital reimbursement.

DRG's have focused a lot of attention on length of stay, and created a new thing called product line analysis. People, instead of looking at just patient days and admission, they are looking at patient days and DRG 89, and patient days and DRG 123. They have just made things a little more scientific in terms of their kinds of analysis that we can do in terms of the patients that are coming to the hospital.

The only problem with that is that sometimes when we look at 470 DRG's, we think we can get pretty scientific, and we think that we have a good system that is going to describe all the patients that are coming to the hospital, and I would suggest that DRG reimbursement is relatively inaccurate or a poor way of determining how much payment should be received by the hospital.

Some of this is due to the fact that we have about 20,000 diagnoses codes that are crammed into 470 DRG's, and something gets lost in the shuffle, but we do run into some fairly severe problems.

They have become especially problematic for small hospitals just because of their numbers; and when we have a 30-bed hospital, like Mount Ascutney treating a patient, running up total charges of $50,000 and receiving $7,000, we can talk about incentives in terms of how they can try to make money on certain patients; we will have to make money on a lot of patients to make up that approximately $40,000 loss in revenue or in terms of cost.

It is just not one example; there are a number of examples like that. There are certain DRG's, and I understand that we are going through a recalibration process right now, but there are still certain DRG's that appear to be losers in terms of patients coming in and if they require intensive care unit services, the hospital knows that it is going to lose money; it is just clear and simple; and I think that is the kind of problem that, you know, people expected would be corrected with the 470 DRG's, and it just hasn't.

I think we also have some problems in terms of the definition of what's an urban area, and what's a rural area in terms of the wage index.

Currently, they have two urban hospitals in Vermont—Daniella and Medical Center Hospital of Vermont. They receive approximately $700-$800 more for any given DRG than any other hospital in Vermont, and some would argue that hospitals in St. Albans or Middlebury are competing for essentially the same share of employees, and there should be some, perhaps, better gradation between the urban and rural areas that would help created a less finite difference between the urban and rural hospitals in terms of their reimbursement.

Now, as folks have said, we have a lot of things happening in addition to DRG's. One of the things that you know we have all seen happen in the State of Vermont is the dramatic decline in hospital volume, both in terms of patient days and in terms of discharge. I am not sure that is all due to DRG's. I think DRG's played a part in it; I think there was a 5-week television series called "Patterns of Practice." I think that had a part in it.

I think the higher deductible for Medicare recipients had a part in it. I think just changing patterns of practice in terms of—as new things come out, physicians discover that they can treat patients either for a shorter length of stay or with home care that five, 3 years ago, they couldn't do at home.

So, we have seen an impact on a number of fronts. In terms of the first 2 years—and that means fiscal year 1984 and the current fiscal year we are in—we show the first 2 years of prospective payment. I would say that the hospitals have probably, in Vermont, have done as well as they would have under the TEFRA rules.

Now, the problem is that we are working in a situation where we get a freeze on the Medicare budget. Now, the whole system was set for an inflationary increase every year, and now that has stopped, and we have got new words, called "policy target," "ineffective practice equals 2 percent decline in the amount received."

I don't know what the 2 percent—I don't know what ineffective practice means. I don't know where the 2 percent came from, and I read the regs several times.

But I think that what we have run into is a situation where the program is not going to be funded.

If the program isn't going to be funded, it really doesn't matter what type of mechanism we used to send money to hospitals or nursing homes or anybody else. If the money isn't there, then it is not going to work very well; and I think that's the kind of problem that we are running into right now.

So, only in terms of Vermont's small rural hospitals, we expect a 2-3 percent decline in reimbursement for fiscal year 1986, as compared to fiscal year 1985.

And that just doesn't make any sense. I think what we are going to see is a rather dramatic cost-shifting onto Blue Cross, privately insured and self-paid patients.

Now, the kinds of things—I have heard a number of things. I'll skip a little bit here. A couple of comments on things that have come up this morning, and this afternoon. One comment was in your notes, Congressman, regarding what brought the change.

There has been a number of studies nationally that have shown the reason that for-profit chains are doing well is that they don't have lower costs; they have higher costs. They also have higher charges, and they do better on their reimbursement.

So that I think that there is a misnomer out there that for-profit chains are doing well because of lower costs and better productivity; it doesn't appear to be the case. There is no doubt that their access to capital is going to give them a distinct advantage in the future, especially if we see the elimination of tax-free financing for hospital bonds.

Mr. JEFFORDS. Let me interrupt you there. Isn't a part of it also that they are careful about who they bring in as patients and that they do not service patients who can't pay. So in this way they end up being able to lessen the burden that other hospitals have in trying to fund patients who are unable to pay?

Mr. BRINES. I don't think that has been a problem, actually. I saw that—I think it was a 60-Minute show where they showed a hospital in Texas, you know, refusing patients.

I think actually there have probably been some stray examples of that, but I think what they have done, more or less, has been very particular in terms of which hospitals they bring into the fold. That they take a look at the way it is indexed. They take a look at the situation, the reimbursement system of the State prior to acquiring a hospital.

Mr. JEFFORDS. Well, whether it is deliberate or not would you agree that that would appear to be the main reason?

Mr. **Brines**. I think it is a question of reimbursement expertise, more than cost saving. I think that their ability to generate a good cost report in a cost-driven State, or their ability to work a system is probably what is really making the money for them, more than the kind of patients they are treating or the actual production costs, in terms of treating for those patients.

There have been a number of national studies on that.

Mr. **Jeffords**. Well, is that a matter of lack of education in our own hospitals on how to get maximum reimbursement?

Mr. **Brines**. Well, I think the problem is a lot of nonprofit hospitals don't see, are or not interested in raising costs to improve reimbursements in some situations, and I think, you know, you have that kind of problem.

Also, you have got some situations where what's left is—in terms of if there, if you will, cherry-picking hospitals, then that leaves a comparison group that is not necessarily a good comparison.

So, I think it is sort of a twofold problem.

Mr. **Jeffords**. Thank you.

Mr. **Brines**. The swing beds came up. I have been working with Grace Cottage Hospital in Townsend, VT. It is a 19-bed hospital. They are certified for swing beds. They have been certified for swing beds for over 1 year. They still have not been reimbursed correctly by Medicare, according to regulations.

We are still working but we are far from getting reimbursement for them. I think that is one of the problems in terms of the swing bed program is theoretically you are supposed to be able to treat that patient as a discharged patient when the patient goes from the acute care component to the nursing home component, and right now Medicare is disallowing it.

Now, hopefully, we'll make some progress, but I think that's the kind of thing that is going to keep that program being successful anywhere.

Now, we're taking our lead from Kansas where there has been a number of swing bed programs in existence for a lot longer than we have had them, and the fiscal intermediary and the region I office for HCFA has said, "Yeah, that's Kansas. They don't know how to do it, so we're going to deny it."

And we are still writing letters, and hopefully we'll be able to turn the thing around, but that's the kind of thing that is going to make that program, certainly, a lot less palatable to other hospitals.

They'll say, "Gee, are you getting your reimbursements straightened out yet?" "Not yet, but we're working on it."

So, I think—there are still a few bugs in the system.

The last thing I would like to leave is—we've talked a lot about nursing home patients in hospitals, waiting for nursing home beds. Somebody said earlier that they thought perhaps the problems had lessened. It doesn't appear to be so. About 8 percent of all the patients in Vermont hospitals on any given day are awaiting nursing home beds. That's a lot of patients, and there is no place for them to go.

We have conducted a study——

Mr. **Jeffords**. What is the average waiting time?

Mr. **Brines**. It—well, I've got it in here somewhere, but it doesn't come to me.

I think it differs in terms of the dependent class, and the kinds of patient that we are talking about. The kinds of things that we found is, you know, obviously the No. 1 reason for a patient waiting is that there is no bed available.

But then we found out that there are other problems, such as the demands in terms of patient requirements, and the fact that you can get a reimbursement system for nursing homes that pays $55 a day, whether that patient is a low-care patient or a high-care patient.

And that creates a problem in terms of the nursing homes that, obviously, if they had all the costly patients, and they were reimbursed at a fixed rate, perchance they would go out of business, and that doesn't really help anyone.

I will leave you with a copy of the complete report that we had done on this problem, plus an executive summary for you and the other Congressmen.

Mr. **Jeffords**. Thank you.

Vera?

[The report of the Vermont Hospital Association retained in the committee's files.]

STATEMENT OF VERA RYERSBACH ON BEHALF OF THERESA TOMASI

Ms. **Ryersbach**. I'm here representing Theresa Tomasi, from the social work department, Medical Center Hospital in Burlington, VT.

And I guess, as social workers, we look at systems, total systems, and I have Theresa's statement which I will read. It speaks to the entire system of people coming into the hospital and what kinds of care are provided, and what is being covered in various areas.

The DRG system represents yet another restriction to the easy access and availability of medical care. To the elderly, who had been promised a medical Medicare bank list, this is another step in reducing care to a much smaller snack.

In addition, today's medical system is extremely complicated, and truly impossible for most elderly people to understand. Their perception of hospital benefits is quite different today than their perception of 10 to 15 years ago.

And there are so many revisions and restrictions that it is difficult for any one patient to understand what is actually covered by third party reimbursement.

It is often confusing and bewildering to patients and families, where patients with severe medical problems that they are being told that they are no longer require acute hospitalization and must move within the system.

It would be very helpful if we had one comprehensive, understandable system not having to deal with exclusions and exceptions.

It is difficult for those of us in the field to keep up with the changes and modifications to say nothing about a patient or a patient's family who uses the medical system infrequently.

DRG's have encouraged hospitals to focus more sharply on their admissions policies. Thus far, at our hospital, we have not denied anyone admission for either medical or impelling social reasons because of the DRG.

However, we do take a very close look at patients coming into the system to see if their medical problem really does require acute level of hospital care.

This plays particular difficulty with elderly patients who may not have an admittable medical problem, but the medical problems combined with the social problems, makes it questionable that the patient can be maintained safely at home.

An example of that is that you might come in with a problem of incontinence that your local physician cannot adequately take care of in the office, and in the process of getting that straightened out, they discover it's Alzheimer's disease, and in the process of learning about that, you discover that the family really has watched this person deteriorate over an extended period of time, and really can no longer take care of that patient any more.

You come in with one kind of problem, which medically is resolved rather quickly, but you end up with a much larger problem, and that is the patient who has a serious, progressive, deteriorative disease and no place to go.

Once a patient is admitted to the hospital, understandably much attention is given to the DRG. The system is exerting much pressure to discharge within the allotted number of days, and the physicians seem to be responding appropriately to the message of good medical care with proper regard for DRG's.

However, the medical problems are not the sole consideration, particularly for the elderly person being discharged back into the community.

Although the patient's medical problems may no longer require acute care, medical in combination with the social problems may well make it very difficult for that person to return safely to her home environment within the allotted DRG time.

A patient may be transferred to another hospital or to another facility, a skilled nursing home, an intermediate care nursing home, or you have two levels of community care homes here; or they can go home with home health services or other kinds of community services, and if very fortunate home with an independent status.

In this area, there are sometimes long waits for nursing home beds, particularly with patients who require a great deal of care.

With the difficult to place patient, for example, total care or the disoriented, belligerent patient, long-waiting periods are common, and appropriate placement plan may well exceed the DRG date by many days.

The next level of care, custodial homes, are very poorly funded, allowing little opportunity to adequately meet the patient's needs. They are ill-prepared and ill-equipped to handle any special needs patients.

This network of homes is necessary to help maintain people's independence as long as possible and should be better funded.

It is a dramatically cheaper rate than that of either hospital or nursing home and if these homes were functioning well, they could prevent the usage of more restrictive and most costly alternatives, and I think you spoke to that point very well.

The first plan preference would obviously be to return the patient home, linking patients with home health services and other resources.

We have excellent home health services in our communities. However, these agencies are also being affected by reimbursement restrictions. That is patients who require a great deal of care, 7 day a week maintenance care are not being reimbursed by Medicare.

The system mandates these patients should be either in a nursing home or in the hospital. Thus, the system is squeezing at both ends, forcing the use of more restrictive, expensive delivery of medical care.

It is all very well and good to be responsive to DRG's, but we must plan a reliable medical alternative if this does not compromise medical care.

If we are reducing home health agencies' funding and in addition asking patients to leave the hospital facilities sooner with increased medical needs, we must then make sure that our community resources are well in place and adequately funded.

There is a great difficulty finding immediately available, appropriate beds for all patients needing transfer.

Certain types of patients wait a longer time for transfer. The hospitals generally run an average of 15 overstayed patients per day; and we have some statistics on overstay, and it hasn't changed probably because of the influence of the DRG. In 1983 we had 117 patients requiring a total of 5,007 overstayed days. In 1984, we had 401 patients requiring a total of 4,488 overstayed days.

And the projected figures for 1985 if we continue the way we have in the first few months of this year are that we will have approximately 482 patients in overstay situations, with a total overstayed days of 3,357.

The private pay overstays in 1984, for example, we had 72 private paid patients, and they overstayed a total of 418 days.

This year we anticipate—no, I think so far that those 4 months, we have had 45 private paid patients and a total of 160 overstayed days.

And I think they generally do better in terms of not having as many overstayed days because facilities obviously prefer to get full payment rather than the rate that Medicare or Medicaid pays.

Private patients generally move much more quickly through the system than the Medicare-Medicaid patient, and certain patients, as I said before, such as the disoriented, confused patient, or the total care patient requiring much nursing time move very, very slowly through the system.

Patients overstaying 30 days are evaluated for placement in the mid-State region, and this has been something that we have instituted since the DRG's at our hospital.

While patients overstaying 60 days are evaluated for placement in nursing homes statewide, this is done for two reasons. One is obviously the financial reason as these patients represent many unreimbursed stays.

The other reason is related to the well-being of the patient. An acute care facility is not an appropriate place, particularly for elderly people, to remain for long periods of time in an acute setting often results in depression and disorientation.

Patients need much stimulation and daily orientation in order to remain optimally functional.

Movement of patients outside their living area surely represents personal hardships. Spouses and other family members find it very difficult to maintain frequent contact when placed long distances from home. This certainly isolates patients and reduces their quality of life.

Fortunately, we have not yet had to do this; nor we have had to do this but a few times. But the potential for having a medical system that greatly pressures discharges opens up this kind of possibility.

At best, it is a discharge system of little individual choice. Because of the scarcity of nursing home beds, the patients must take the first available bed not allowing for personal choice. For the private patient no longer requiring acute care if the nursing home bed is not available they are forced to pay their own hospital bills during the time that they wait.

This merely depletes the private patient's savings and produces a great hardship to them.

We have been very fortunate in our hospital setting to have the resources to not begin to make decisions for patients strictly on a financial basis.

At the present time, patients are admitted, as requested by their physician, and where there is a need, they are kept in the hospital until an appropriate discharge plan is made.

This is not true in all hospitals, and certainly, as the system tightens, we may also not be able to maintain that final system.

We must remember that the frail elderly do not accelerate well. Doctors, social workers, nurses, physical therapists, and all the players have been very responsive to DRG's, recognizing the necessity for cost containment; however, it is important not to pressure the medical system so much that it results in insensitive responses to patients' needs.

As health professionals, we would not want to support or encourage this program. Should the system become any tighter than it is now, we will be making choices that are really not in the patient's best and emotional interest.

We need to look carefully at a balance between the medical need, the social and the emotional needs of the patients as they surely have a direct bearing on how patients can respond medically.

Too early discharge often results in a readmission. Too many frequent moves in elderly patients often result in disorientation and decline in their medical condition.

At the present time, patients do not understand the medical system, and are moved sometimes too quickly to an alternative setting, often not of their choice. Thorough thought and planning must be given toward vastly important medical system. Thought should be given to having one comprehensive system with total coverage for all patients.

Mr. JEFFORDS. Thank you very much.

I am afraid I have to interrupt here to thank Congressman Blaz for his service in coming here. If you don't leave pretty quickly you will miss your plane.

Mr. **Blaz**. Thank you very much. Mr. Chairman, I was so enthralled by this thing, I forgot I was supposed to catch a plane here.

Mr. **Jeffords**. Yes, right.

So, if you have any comment you would like to make or question you would like to ask, before leaving I'd like to give you the opportunity.

Mr. **Blaz**. All right. Thank you very much.

I don't think I have any more questions. I am just so grateful I came. I have never done this type of field work before, and I am astonished at the amount of information that has been presented here today.

Normally, these things have a tendency to be just kind of superficially presented, but there have been some very candid comments here, and very good statistics, and I can tell you this, I have become better educated here today, and it has brought a new dimension to the problem that I have never been aware of before.

Granted, I am a new member of the select committee, but at my age, I had better start paying attention to what is going on.

And, once again, I want to thank you publicly, my friend, for the initiative you have taken. I think you have given us some sample of what to do in our own districts, because this is only the second time I have participated in a district hearing, I may well be volunteering for additional hearings because it has been so informative. It really looks different when you sit back in Washington, and all these lobbyists come in and give you this nicely typed, slick pieces of paper. It is something else when you see a doctor saying, "I'll be damned."

When they start pounding the floor and then you see the candid remarks from the patients as well as concerned nurses in the association.

So, I'm profuse in my expressions of appreciation, but it is sincerely expressed, and I want also to thank our chamber of commerce of Vermont for the good things they've got to say about this fine State.

Mr. **Jeffords**. Thank you.

This maple syrup will help sweeten up your State.

I don't think that it is a common item in Guam, but I am sure you will find it good.

Mr. **Blaz**. Thank you very much.

Mr. **Jeffords**. Goodbye, now.

I thank you again for your testimony, I would like to say, in sort of a followup of what Mr. Blaz said—I cannot undergrade the importance of these field hearings. I know that there are some that may feel that they are a waste of time and that it is not necessary to participate. I am sorry to hear that kind of cynicism.

But I would like to point out that this will be one of probably three field hearings throughout the United States, where we will be gathering information to send to Washington on this issue and as pointed out previously the kind of testimony that you get here is much more meaningful to myself and to the other members of the committee and to Congress generally because we get a better feel for what is actually going on in the field.

We greatly appreciate the time and effort that you and all the witnesses have put into your testimony.

Doctor, I appreciate your concern and Griff Bates' concern over the 3-day waiting period, and also the lack of level 1 and 2 beds, et cetera.

I can assure you that I intend to pursue these issues until we get an answer to some of these questions.

As we go through a period of learning to use new methods to try on the one hand to bring costs under control, we must, more importantly, ensure that the resources that we have available, and unfortunately these resources are limited in view of our deficit problem, are better utilized, and used in the right places, as has been pointed out here today.

It is a time to be concerned, and I am well aware, as you are, that unless the health care profession and others stand up and shout and express their problems and articulate the needs of the country. If we don't push, someone else will and they will get the available resources.

I appreciate your participation in this effort. I do hope that in view of the testimony, we can all find some better answers to the problems that we have articulated. I want to thank you very much for your testimony here today.

If you have any further comments, please take this opportunity as I did cut off your statement in order to make sure that Congressman Blaz got his airplane.

If you'd like to add anything to your statement, please feel free to say so at this time.

[No response.]

Mr. **Jeffords**. My plane is not for another hour, so I have plenty of time to listen.

OK. Thank you very much.

Our next panel is Sally Conrad, the Chittenden County State senator, Brian Pritchard of the Vermont Office on Aging; and Don Horsley of the Vermont Office on Aging.

Will you please come forward.

Mr. **Jeffords**. Sally, nice to see you again.

Ms. **Conrad**. Nice to see you, Jim. I have been elected by the group to go first.

Mr. **Jeffords**. Please proceed.

Ms. **Conrad**. I'll be brief.

PANEL EIGHT, CONSISTING OF SALLY CONRAD, VERMONT STATE SENATOR, BURLINGTON, VT: BRIAN PRITCHARD, VERMONT OFFICE ON AGING, WATERBURY, VT; DON HORSLEY, LONG-TERM CARE COORDINATOR, VERMONT AGENCY OF HUMAN SERVICES, WATERBURY, VT

STATEMENT OF SALLY CONRAD

Ms. **Conrad**. As you know, I am a member of the Vermont State Senate, from Chittenden County, and a member of the Vermont State Senate health and welfare committee, as well as the Health

Policy Corp., and I want to compliment you for holding this hearing today.

Not only has it educated you, I think, but it has also educated me in the same process.

And I am really here, not as an expert, but really to underscore and echo some of the comments that have been made earlier, and at the outset I really want to second Dr. Ferry's comment. I implead that the Federal Government reorder its priorities by placing more emphasis on the basic human needs of our citizens rather than funding sophisticated weapons systems whose feasibility really is questionable.

OK. I also really want to underscore the considerable stress placed on community-based services by a reimbursement system, which is not geared to community-based services but to institutionalization.

We know that home health agencies are seeing patients who need more and more complex care at home, and increasingly these are people who, in the past would probably be eligible for level 2 nursing homes.

These people are generally homebound; they suffer from such diseases as debilitating arthritis, heart disease, hip fracture, stroke, multiple sclerosis, Alzheimer's disease, and cancer.

We know that the home situation of many elders differs considerably. Many elders live with a spouse, often a frail couple lives together looking after each other. There's many times an elderly parent working with an adult child or living with an adult child who is working and under stress for caring for that adult parent and working themselves.

We know that many elders live alone. We know, too, that families do not want to institutionalize their loved ones. We know that elders do not want to become institutionalized, and according to current research, the largest portion of long-term care services are those hidden services, provided by families at the informal care system—friends, again families, churches, voluntary groups.

We as policymakers must be extremely aware of the tremendous stress on a family when a support network does not fit.

Now, what do we need to do? We need to educate society at large, all the various publics about the changes demographically, that the over 85-year-old society is the fastest growing group of our population, and that approximately 30 percent of that group will need high-level long-term care sometime in the foreseeable future.

We need to expand and properly fund those community based services which support that informal network of family and friends, again where they do exist.

We need particularly respite care, homemaker care, companionship care, adult day services, and myriad services of specialized housing, and specialized transportation.

In addition, I want to speak to the mixed message that we seem to be hearing lately from some of our researchers, some of our spokesmen from the administration.

Contrary to what we hear, the economic status of all elders is not improving, particularly that of older women.

In Vermont 71 percent of all Social Security recipients—and that is 89,000 folks—depend only on Social Security for their principal source of income.

Here in Vermont, the average benefit is $341 a month, which is $40 below the national average. Here, we are an agrarian-based economy, as you know, and that means, we have a lower benefit.

Of the 10,000 SSI recipients here in Vermont, an additional 2,000 could receive SSI, but will not file because it is a matter of pride.

We must recognize that many people living on limited income could not possibly afford to buy out of their own pockets crucial community-based services, such as respite care and homemaker services, which are not now covered by public dollars.

We must infuse public dollars into these services to prevent and retard greater costs of institutional care. We must question—and I agree with you—we must question the affordability of long-term care insurance.

We must also be extremely careful to monitor what these policies cover because we don't want to give folks false impressions. We want to be sure that these policies when they come into effect cover the needed services.

In conclusion, let me reemphasize the fact that our current long-term care policy is driven by the reimbursement system, not many times by what is in the best interests of a patient.

As the former director of the Senior Volunteer Program of Chittenden County, I know full well the extent to which older people contribute to the welfare of our country, many times despite debilitating health conditions.

I would urge your help in safeguarding that valuable resource. Thank you.

Mr. JEFFORDS. Thank you very much.

Brian.

STATEMENT OF BRIAN PRITCHARD

Mr. PRITCHARD. My name is Brian Pritchard, and I work for the Vermont Office on Aging. One of the advantages in going this late is that you can pick up on a couple of questions that got asked before they got answered.

One of the questions I would like to answer which was answered for Congressman Blaz was his question about Medicaid share and what the State pays versus the Feds.

It is not a choice, we are told by the Feds what our share will be. We can elect to either provide or not to provide some services under that, but we are told what our share will be.

The second question was commissioned by the person who got asked the question. I just happen to remember it. The commissioner of hospitals did a study, or commissioned a study on people awaiting placement in hospitals.

The average is something around 30 days for a person awaiting a place in a hospital. A most interesting answer is that for a person who can pay for it, that nursing home care themselves—that is to say, a private pay—the wait is about——

Mr. JEFFORDS. Excuse me, let me interrupt you.

You said 30 days waiting to get into a hospital——

Mr. **Pritchard**. Excuse me, into a nursing home.

Mr. **Jeffords** [continuing.] You mean 30 days to get into a nursing home?

Mr. **Pritchard**. From a hospital to a nursing home.

For a person who can pay for their own care, the wait is about 15½ days; for a person on Medicaid, the wait is 42 points, 6 days. And that tells us also something about the two-tier medical system.

Mr. **Jeffords**. Where are those people while they are waiting?

Mr. **Pritchard**. They are waiting in the hospital.

I work at the Vermont Office on Aging, and my job is to train and support the direct service advocates, to help elderly Vermonters obtaining benefits and services.

Part of my job involves being with those advocates, during case conferences, and I find it interesting that both the issues and the tenor of the testimony that I have heard today is similar in case conferences.

The general tenor that I hear is that we are victims, no matter who we are. Regulators are saying we are just carrying it out by the book. The physicians feel like victims because they used to use Medicare to provide a lot of services that were inadequately covered by the long-term care system.

They can no longer use social admissions to hospitals to provide respite care that has never been there and never coming.

Nurses are getting, and home health agencies are serving narrowing definitions. They are asked to do more and more and more with less and less and less.

And, of course, the clients that we have heard about, the patients that we have heard about, the real people have almost no choice at all.

We are victims. These people, I submit, are saying that they are victims because of that essential element of choice. They feel that they have no choice in running the system, and therefore they have no responsibility in making it work.

The temptation for work, the Federal legislation, is to ask us how to fix the system, how to fix this regulation or that.

I submit to you that you should not ask that question. Don't try and fix the system yourself. The service providers out here can fix it for themselves if you allow them to. Hold us to the responsibility, of providing a long-term care system, but let us figure out how to make it happen.

Your choice and responsibility is to recognize the demographics that we have heard so much about, and pay for the services that we all give too much lip service and too little money.

Current Medicaid regulations and CAPS are an illustration of where our policy for our budget is different from our policy that we give lip service to.

Here in Vermont we discuss the waste restrictive alternative of offering services to a person in the least intrusive place necessary.

Yet, last year the Agency of Human Services spent $28.5 million on nursing home care for the elderly, and we spent $1.5 million for home health care in Medicaid funds.

As long as we have a policy that we will only help people with long-term care by the Medicaid Program as a primary payer, we intend have a national policy that we will impoverish our elderly and frail before we will help them out.

It is the Federal responsibility to make a choice to recognize that need. It has been ours to carry out that service.

I agree with Senator Conrad that private insurance for long-term care at the moment denies reality. Cost shifting to the individual at this point does not make sense.

In 1965 we passed the Medicare law because we were concerned about the catastrophic costs of older people, of health care.

Twenty years later, in constant dollars, people who are elderly and frail are paid more out of their pocket than they were before we solved the problem with Medicare.

To then ask them to have higher deductibles, higher coinsurance, higher premiums, and find money to pay for long-term care, private insurance is just irresponsible. That choice is irresponsible.

Is there another way? I submit that there is. Don is going to talk, may talk some about some of the examples he knows well in this country. I would like to bring an example from an article in the New England Journal, May 23, and I have copies for you.

I would like to read just some of the conclusions from lessons learned from Canada and their universal long-term care benefit package.

The three Canadian Provinces that they studied in this group have added long-term care to the package of universal health benefits at different times and in different forms.

In each case, public expenditure for long-term care increased at a higher rate than expenditures for the rest of the health care system.

It is going to cost us more money.

With regard to the substitutability of community-based care for institutional long-term care, the Canadian experience confirms the conclusions of American demonstration projects.

The availability of highly developed community services does not seem to have reduced the supply of nursing home beds. We are still going to need those nursing home beds. It is going to cost us more to be responsible.

A commitment to community care represents the desire to serve persons who need care and whose needs are not being met by nursing homes.

It is the response to the often-expressed preference of older persons to remain at home as long as possible. At the same time, it is a politically attractive program—that's why I mention it. For a relatively controllable cost of about 10 percent of the nursing home budget, the Government can offer a very desirable package of services. Although we did not find evidence of displacement of institutional care in the aggregate, the presence of an alternative system of care makes feasible a policy to restrict the growth of the institutional sector.

Despite the fear expressed in this country that expanded home care benefits might lead to runaway use, the Canadian experience shows a consistent pattern of demand leveling off after about 3 years.

As long-term care benefits have been introduced over the past decade in various provinces, the rate of health care spending in

Canada expressed as a proportion of the gross national product has remained below that in the United States.

The Canadian approach exemplifies somewhat differently in each province—read for us, state—has obvious benefits for consumers.

Residents do not need to impoverish themselves and their community-dwelling spouses to obtain nursing home care.

A few organizational observations are in order. The Canadian experience confirms that of other Western countries. Publicly financed health care programs are best run at sub-Federal levels.

Manageable geopolitical units are essential. In Canada, the provinces are the primary units, but much of the control is often delegated to smaller regional units, as we wish to do in Vermont.

Historians have cited Government's ability to act in the interest of the needy as an achievement of modern civilization.

The U.S. response to the challenge of long-term care is a test of our social development. If we pursue a policy of individual responsibility, we repudiate the progress made since our early times of taming the wild frontier.

The Canadians have settled the same frontiers but have learned different levels. They have introduced a universal program of long-term care, not merely since the elderly have earned the benefits, but because the role of society is to provide for those in need.

Thank you.

Mr. **JEFFORDS**. Thank you, Brian.

[The full text of the New England Journal of Medicine article retained in committee's file.]

Mr. **JEFFORDS**. Please proceed.

STATEMENT OF DON HORSLEY

Mr. **HORSLEY**. I'm Don Horsley, and I am the long-term care coordinator for the Vermont Agency of Human Services, so in addition to working with the elderly on long-term care, I am also concerned with programs and services of the physically disabled, the chronically mentally ill, and developmentally disabled.

I am talking to you from that perspective as well as from about 13 years of experience in long-term care, working for the States of Massachusetts, Pennsylvania, and Wisconsin, and several years as a "beltway bandit" in Washington, where I was doing some research for the Administration on Aging for the U.S. Conference of Mayors, and the Governors of about 40 States.

My interest in wanting to come here today is to urge you to carefully review the results of the numerous long-term care of research and demonstration projects that have gone on around the country in the last decade.

I think that in doing so, we find a common set of concerns and conclusions that those projects have reached, and there is a starting point. I think you go back to 1979 with one of the Comptroller General's reports to the Congress, and I have cited this in written testimony you have.

The Comptroller General's report kind of set the stage for literally dozens of research and demonstration projects—and what it came down to are four basic conclusions and recommendations to Congress:

And the first is that if we are going to make some sense out of the high cost of Medicaid and over-reliance on institutional care, then we ought to provide a comprehensive needs assessment for anyone seeking admission to a nursing home, and make that compulsory for people who are eligible for Medicaid or Medicare, and optional for anybody else.

Second, that if we are going to try to give people alternatives to remain in their own homes and own communities, we have to provide real solid assistance in accessing those services and obtaining them.

And, third, if we are going to provide that kind of assistance to them, that person will have to be vested with both the authority and the responsibility to act as an advocate for the client and act as an intermediary for all the other service providers.

And, fourth, and it is essential. It is especially critical. There has to be some kind of gap-filling resource that is available to pay for the goods and services that nobody else can or will pay for, the kinds of services that just don't meet eligibility criteria, the kinds of goods that may be necessary to make a home accessible, for example. The funds just aren't available.

So, the information from the research and demonstration projects, like the National Channel and Demonstration Project, systems development grants for 15 States, the intensive effort the Robert Wood Johnson Foundation has put into this area in the last 5 or 6 years, all come down to the same basic conclusions; and, at the same time, we are a long ways from making sense of the whole of long-term care.

We don't have a system. We have a nonsystem, and it is made up of Federal, State, and local agencies in the public sector, and a very complex mix of proprietary and nonprofit, and volunteer, and informal care givers in the private sector.

And it is a nonsystem that is driven by conflicting requirements of literally dozens of different funding sources.

You are aware of those funding sources, and I think Gary Markotte this morning used a chart that we developed in the Agency of Human Services to show all the intersecting lines.

At the same time that I say that, I know that we are all committed. We want to do better; we want to provide better services for people in need. But I think that we are more accountable to our funding source than we are to our clients.

If we look hard enough, we think there is also certain logic in that. There are original concerns that come to the fore, sometimes in hearings like this, that ultimately get translated into some kind of ultimate solution in the form of Medicaid or Medicare legislation, or the Older Americans Act, or block grant legislation.

And once Congress gets through with it, you have to turn it over to the executive branch and they go to work on the rules and regulations, and it gets passed on to the States where a few more conditions are laid on to it, and we finally get out to a lineworker somewhere here in Vermont or elsewhere who says to a potentially eligible person:

"You can have this service if you meet the following eligibility criteria."

And this has probably transpired over a period of years, and that potentially eligible person, you might hear them murmur, "Does this really have something to do with my original concern?"

I'm not suggesting at the same time that we do away with the rules. We do have to be accountable. The resources are limited.

What I am suggesting is that we may have too many sources of public funding with too many conflicting strings attached. We have, for example, services that are client-specific—for the elderly, for the physically disabled, for the mentally ill, and so on.

At the same time, we provide other services that are location-specific—in nursing homes, in communities, in people's own homes.

But the requirements for where and when and for whom and for how often work against the kind of coordination and cooperation that can best respond to client needs.

It is no wonder that nursing home care is becoming the most convenient option for people with chronic disability. And I think one of the points we need to make strong is that the level of care that people need is not the same as the location of that care.

Someone who is qualified for level 2 nursing home care does not need to be in a nursing home to receive level 2 care.

We know that for a fact. But acknowledging that fact allows us to begin considering a broader service universe, and I use the term "universe" deliberately, because I am talking about the fact that human service professionals come up with a lot of ways describing the way we plan and deliver services, and we hear a lot of talk, for example, about the continuum of care, and that connotes a range of services, beginning with the least amount of intervention in the person's life, being information referral on one end, to 24-hour day institutional care at the other end of that spectrum.

And what it does is lay out for us—it suggests that people move across that continuum as their service needs become more intense, but the fact is that people don't just move it across gradually. They have to plug into that service continuum at some time at many different points at the same time, and it cuts across the entire continuum.

It looks good on paper, and it helps us explain what the whole range of service is, could or should be; but people don't lose their lives in such a logical and orderly way.

So, I think that if we are truly intent on developing a long-term-care system, we need to look at it first informally from the client's perspective, and we need to make the client the center of the service universe; and we need to understand that they go into that system usually at a time of crisis and that they need some kind of guide to through that universe, and they need some guideposts along the way.

And we need to recognize as professionals that the people closest to that person are not as service providers; it is the people, their family and their friends; and then when we talk about informal care givers, I think it is something that we need to know, too, that it is a euphemism for women. Women provide the bulk of long-term care in this country on an informal basis. It is daughters and daughters-in-law; it is wives; it's nieces, and so on.

And we need to understand that the closest beings are not us but family and friends in the community—and I'll put a line in here, that we need to do our best to support, and that's the plan, where people can who want to do for themselves, to let them know that in Vermont and elsewhere you can get there from here on the long-term-care road.

And if we are going to be true to this view of the universe, I think we do need to focus on those four basic conclusions that the Comptroller General suggested, and what virtually all of the other research and demonstration projects have suggested as well.

So, we are attempting to incorporate those four basic concerns in Vermont's long-term care package. We do it the same way, but the same frustrations that are in dozens of other States.

And what I am saying is that there are essentially 50 States and all the territories out there reinventing the long-term care wheel over and over again, because we keep taking a top-down approach that focuses on the organizational issue where major decisionmaking is conducted only at the highest levels of the organization or the system, and where control and accountability are too often the keynotes to that.

And I don't expect you and other Members of Congress can ever have the best answers on how to meet the needs of Vermont and all of its people. Nor can we tell you the best way to meet the needs of other State and territories.

But I think each of us needs to be a part of the solution, and each of us has some of the answers, and I am suggesting to you that we change the way we view the long-term care in the universe; and that is a change in the way we consider and shape it, so that we perceive every person and organization and governmental level that they have unique role to play and each has its own integrity.

And we each have a multiple role, and I think that is part of looking at comprehensive assessments of clients, that they have strengths as well as weaknesses. They have abilities as well as disabilities; and for far too long I think we have taken a medical approach to that, where we look only at what is wrong with people, the same way we look at only what is wrong with organizations.

I think we can look at what is right with them as well.

I think the available evidence points to the need for all of us to conceive of our roles in terms of what we can do, not to control us at the State level, down to locals, or the Federal Government to the State, but to support each other's efforts, in that flow of responsibilities between clients and workers and organizations and lawmakers.

What we really want for clients in the long-term-care system is for them to be able to make informed choices. And I think if we are going to achieve that goal, we have to adopt the same one for those of us who are responsible for putting the system in place and operating it.

And that requires a major effort at congressional and State level. Let's refrain from adding new rules and regulations to govern the system. But it calls, I think, for Congress to establish a framework for long-term-care services that allows States and service providers to meet individual needs in individualized ways.

Thank you for your time.

Mr. JEFFORDS. Thank you—thank you for your testimony. I appreciate all the effort that you have put in.

[The prepared statement of Mr. Horsley follows:]

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STATE OF VERMONT
AGENCY OF HUMAN SERVICES

To: Hon. James M. Jeffords, Presiding
Public Hearing of the House Select Committee on Aging
Montpelier, Vermont
June 17, 1985

Fr: Donald L. Horsley
Long Term Care Coordinator
Vermont Agency of Human Services

Re: The Client's Perspective on Federal Policy and Legislation for Long Term Care

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My purpose in preparing this testimony is to urge you to carefully review the results of the numerous long term care research and demonstration projects conducted throughout the country during the last decade. In doing so, I believe you'll find a common set of concerns and conclusions regarding the financing, organization and delivery of services for people with chronic disabilities.

The General Accounting Office issued a report to the Congress in 1979 that set the stage for literally dozens of research and demonstration projects since then. ("Entering a Nursing Home: Costly Implications for Medicaid and the Elderly," Report to the Congress by the Comptroller General, PAD-80-12, November 26, 1979) The Health Care Financing Administration and the Administration on Aging jointly conducted the National Channeling Demonstration Project and also awarded Systems Development Grants to 15 states. The federal government continues to encourage states to operate Medicaid waiver projects for community-based care. And in the private sector, the Robert Wood Johnson Foundation and other philanthropies have supported research and demonstrations of alternative forms of long term care delivery.

Each endeavor has sought to determine, in one form or another, better means of ensuring that long term care services are available, affordable and accessible to people who need them. Virtually all of them arrive at the same basic conclusions as the Comptroller General's report:

> First, we ought to provide a comprehensive needs assessment for all applicants to nursing homes, compulsory for Medicaid or Medicare recipients and optional for others;
>
> Second, people need assistance in planning and obtaining services if they are to remain in their own homes and communities;

Third, someone must be vested with both the responsibility and the authority for on-going coordination and monitoring of community care services; and

Fourth, there must be a flexible source of payment for goods and services that no one else can or will pay for and which may make the difference between a client remaing in their own community or entering a nursing home.

The information is in, the results are essentially the same; yet we're still a very long way from making sense of the whole of long term care. We do not have a "system" of long term care in Vermont, nor is there one nationally. We have, instead, a non-system made up of federal, state and local agencies in the public sector, and a complex mix of proprietary, non-profit, voluntary and informal caregivers in the private sector. It's a non-system driven by the conflicting requirements of dozens of funding sources, by the urgency of client needs, and by competing demands imposed on the time and resources available to us.

I'm convinced that all of us -- legislators, public administrators and policy makers, planners, service providers -- are motivated by concern for the well being of people in need. We do, in fact, provide an extremely wide range of services to a wide range of people with chronic disabilities. We've become increasingly aware that our true mission is to enable people to maintain their integrity and enhance their independence. But we have fallen short of their expectations and ours. Our resources are dwindling, not only in absolute dollars, but also in our capacity to satisfy increased demands for service and our sense of equity about who receives them.

As committed and as motivated as we are to serving people in need, I believe that we are more accountable to our funding sources than we are to our clients. And if we look hard enough, there is a certain logic in that. If we trace our way back through the rules and regulations, through the eligibility and reporting requirements, we can, for example, find the original concerns that resulted in Congress enacting Medicaid and Medicare, the Older Americans Act and Block Grant legislation. Each piece of legislation resulted from a documented need to provide new or better services, to make better sense of the way we coordinate and deliver services, and from a desire to achieve a balance between institutional and community care.

However, concerns have a way of getting translated into an "ultimate solution" in the form of legislation. The solution gets translated into immutable rules and regulations. After a few more conditions are laid on at the state level, a line worker somewhere has the responsibility for making the final translation to a real person in need of a service. The person is told, "You can receive this service IF you meet the following eligibility criteria..." And if we listen closely I suspect we might hear a potentially-eligible person murmur, "...Does this have some connection to my original concern?"

I'm not suggesting that we do away with the rules. Even if the resources were not scarce, the need for accountability would remain. What I am suggesting is that we may have too many sources of public funding with too many conflicting strings attached. For example, we provide some services that are client-specific -- for the elderly, for the physically disabled, for the chronically mentally ill and so on; at the same time, we provide other services that are location-specific -- in institutions, in communities, in people's homes. We have many of the same services available under different funding sources, but the requirements for where and when, for whom and for how long, often work against coordination and cooperation and what could be the best response to client needs.

That's what I mean when I say that we have a non-system. We simply do not have an adequate and uniform means of allowing frail or disabled people and their families to determine for themselves the range or level of services appropriate to their needs and then making it easy for them to gain access to those services. So long as we professionals are unable to make sense of our range of activities, we can't realistically expect people in need to do so. It is no wonder that nursing home care has become the most convenient option for people with chronic disabilities. And while the incentives continue to favor nursing homes over community care, one of the points we need to make strongly is that the level of care a person needs should not dictate the location in which the care is given.

Acknowledging this fact allows us to begin considering a broader service universe -- and I use the term "universe" deliberately. Human services professionals have come up with a lot of concepts to describe service needs and systems. One of the concepts heard most frequently is "continuum of care". It connotes a range of services that involve the least amount of intervention at one end -- information and referral -- to the most intensive intervention -- 24 hours per day institutional care -- at the other end. The conventional thinking about this continuum is that people will move through it as their needs become more intensive. What is not so easily understood, however, is that most people move back and forth across the continuum, and they may need services at a variety of points on the continuum at the same time. This continuum looks nice on paper; information is portrayed in a logical and orderly way. But people's lives, especially at a time of crisis, are not so orderly nor so flexible that they can fit into arbitrarily defined organizational boxes.

I believe that if we're truly intent on developing an effective long term care system, we need to look at it first and foremost from the client's perspective: the prospective long term care client, most often an elderly woman with limited resources, often finds herself at the center of an alien universe. There is a desperate need for a guide to this universe and for understandable guideposts. There is a need for we professionals to understand that the closest beings to her in our universe are not us but rather family and friends and community -- the people and places providing the majority of care here in Vermont and throughout the country. We need to do our best to support and not supplant what they can and want to do for themselves, to let them know that in Vermont and elsewhere you CAN get there from here on the road to long term care.

If we are going to be true to this view of the universe, then we need to focus on the 4 basic conclusions put forth by the Comptroller General and others. The first, a comprehensive needs assessment, must go beyond the traditional medical model and include information on the person and their family about social, emotional, financial and housing conditions. As important as anything else, such an assessment must address abilities as well as disabilities, strengths as well as weaknesses. The purpose is to provide the person and their family with choices wherever possible on both the location and the level of care.

The second conclusion, that people need assistance in planning and obtaining services, calls for a guide to the long term care universe, someone who is trusted by both the client and by service providers. This service manager may also serve the function of the third conclusion reached by the Comptroller General. It is an accountability function, and it is directed three ways: to clients, to ensure that they are receiving appropriate care as planned; to funding sources, to ensure that eligibility criteria are met and to document future service needs; and to service providers, to ensure that service requirements are adhered to and that changes in service needs are transmitted in a timely manner.

The fourth conclusion, a flexible source of payment for goods and services that no one else can or will pay for, is critical in meeting individualized needs that do not fit our arbitrarily defined set of services.

We are attempting to incorporate these concerns into Vermont's long term care planning -- and we do so the same way, with the same frustrations, as dozens of others states: in short, there are 50 states and several territories constantly re-inventing the wheel of long term care. We continue to rely on the traditional public response to the problems we are confronting -- a top-down approach that focuses on organizational issues and where major decision-making is conducted only at the highest levels of the organization or system. Control and accountability are too often the keynotes of such efforts.

We can't expect you in Congress to have the best answers on how to meet the needs of Vermont and its people. Nor can we tell you the best way to meet the needs of other states and territories. But each of us needs to be part of the solutions we seek. I'm suggesting to you that we change the way we view the long term care universe, a change in the way we consider and shape it: every person and organization and level of government has a unique role to play, and each of us has our own integrity. Moreover, each of us has a multiple role -- people with long term care needs have strengths as well as weaknesses; line workers have critical information to give to their superiors as well as orders to receive from them, and service providers and state and federal government have needs and responsibilities to be met by each other.

I believe that we can create a long term care system that makes sense for Vermont and its people, a system that makes sense at the national level and in each state and territory. And I believe that the available evidence points to the need for all of us to conceive of our roles in terms of what we can do, not to control, but to support each others' efforts in the flow of responsibilities between clients, workers, organizations and lawmakers. We want clients in the long term care system to be able to make informed choices. If we are to achieve that goal, then we must adopt the same one for those of us who are responsible for putting the system in place and operating it. That will require a major effort to refrain from adding new rules and regulations to govern the system. Rather, it calls for the Congress to establish a framework for long term care services that will allow states and service providers to meet individual needs in individualized ways.

Mr. **Jeffords**. One thing I would like to discuss—this is not really related to the subject today, but it is related to our committee responsibilities, and that is that—I was disturbed to find out—apparently, 20 percent of the people eligible for SSI are not participating.

And as you may remember I worked to get a cash-out program for seniors having food stamps in this State, one of the few States that has this option.

I wonder what kind of outreach you have going now to try to improve that participation, in both of those programs, and why this is not as successful as I would hope that it would be.

Mr. **Pritchard**. Well, I think there are answers to both the participation about SSI and food stamps. Recent regulation changes in the food stamp cash-out program have made it that benefits have dropped substantially from—in a period of about the last year the average benefit dropped from about $53 to about $33 in the State, and a lot of—a lot of proud Vermonters, even though the foodstamp cash out was a definite, good idea—and I applaud it highly, and lots of people arguing that just because it is cash—a lot of elderly Vermonters do not want to apply. When you say to them:

> Will you go through this monthly reporting system where all this paperwork for a $10 benefit, which is quite often what their benefit is.

So, the food stamp benefit is just not enough, and that is mostly due to some regulation changes.

Mr. **Jeffords**. Is that true for SSI recipients?

Mr. **Pritchard**. No, with SSI, I am not sure about—some of the numbers are related to income versus resources, whether the person—there are two, actually there are three eligibility criteria for SSI. You have to be either aged, blind, or disabled; and then you have to be income-eligible and resource-eligible.

A lot of the numbers about how many people are not getting SSI are based on the income statistics. We know, for example, from their Social Security benefit that they are below the SSI level, but they may have $1,700 in the bank that they have been saving for a funeral or whatever; and that $1,700 in the bank prohibits them——

Mr. **Jeffords**. You mentioned reporting. Is this required of SSI recipients?

Mr. **Pritchard**. No, SSI recipients customarily get a redetermination about every 12 months.

Mr. **Jeffords**. Thank you.

Mr. **Pritchard**. But we have about 80 people around the State, going around trying to get people on—not trying to get people on benefits, trying to allow, trying to show those elderly people what benefits and services they are entitled to, and if the older person elects to choose to apply and try to gain those benefits, then the person helps them do that.

Mr. **Jeffords**. Have you any idea how successful they have been?

Mr. **Pritchard**. I think they are very successful, and they see about 10,000 people a year. I think they are doing a real good job. I don't think there are enough of them.

Mr. **Horsley**. I just want to take a little bit of an exception perhaps to the—to your apparent conclusion, Brian, that individual insurance would be a failure.

I think that we may get ourselves too tied up with Vermont on that situation, but at least the statistics I've seen with respect to the population that might be advantaged by insurance with respect to the percentage that actually will end up using the insurance, that for certain individuals at middle income and above, that it might be a very desirable program; so I am not sure that you meant to indicate that you thought it would not be appropriate for anyone, but I would agree with you that for low-income States like Vermont, it is not going to be the answer to the problem, and I just wanted to ask you whether that, it is your perception that it would be—it might be a good program, but not like you had solved it, and many of the problems were Vermont.

Is that basically it?

Mr. **Pritchard**. I don't think it will solve many problems for Vermont and that's a lot of matters related to the income question.

I think you have got a really difficult problem. A lot of us can—will see that we might need to go into a hospital, but we want to protect ourselves in terms of insurance from going into the hospital because, one, a car accident, or whatever.

I think that people's intentions about nursing homes make that such a psychological barrier that they won't want to insure enough so that people at this point will want to pay that.

The other question that I have is whether the rest of the system is going to need to change so dramatically that that question will become moot or not.

Mr. **Horsley**. May I add a point to that?

Mr. **Jeffords**. Certainly.

Mr. **Horsley**. That long-term care insurance, if it is limited only to nursing home coverage, isn't going to work, for the reasons Brian stated. But it will be a strong interest in it, if it is going to cover long-term care in general. That covers a much broader population base than just the other way around.

Mr. **Jeffords**. I understand that, thank you.

I am also concerned that, at least in what Brian tells me, that the Federal Government ends up picking up the tab for everything. I don't know whether that was the implication you wanted to make, but you indicated that there were responsibilities that State and localities, were better able to provide while funding responsibility should lie with the Federal Government.

Is that your opinion?

Mr. **Pritchard**. To a large extent that is absolutely true.

I believe that, as other people have said, that it must be a partnership between Federal and State and the individual himself.

As a matter of fact, in the Canadian example, the one that copayments for the person in a nursing home—it's there. It's however $15.16 a day; it is much smaller. But, in general, because Vermont at this point is in a tax status and position that it is in, I do believe that a large part, a major part of the responsibility for providing these kinds of services—well, not for the services, but funding for the services, is indeed Federal responsibility. Yes, I do. I think that is a matter of social policy for the country.

Mr. **Jeffords**. I would only point out that I am not so sure your position is shared by the present administration or perhaps by future administrations. I do think that we have to be ready to recognize that there is a certain degree of validity of the fact that you get a better husbandry of—use of resources if there is a funding participation to some extent by each of the providers.

I think that we have seen that, for instance, in the great problem we are having right now with the Food Stamp Program—and especially in Vermont administration. If there is no State input into the actual money being spent on care, there appears to be a tendency, at least, nationally, toward higher error rates.

So, I think as a matter of national policy, you are going to see the emphasis on shared participation.

I would agree that there ought to be differences in amounts. In areas where you have low-income populations and definite needs there ought to be a lesser degree of participation by the States and local governments. Most of the costs of these programs, which are not within the ability of the States to fund, ought to come from the Federal Government. I don't think, however, that we are going to see the Federal Government picking up the tab completely for these programs.

Mr. **Pritchard**. No; I believe that that does have to be a partnership.

In terms of public policy, I was interested in a speech that I heard a while ago. I found out that there are only two countries in Western civilization that do not have some sort of national health care, national health insurance, if I can say that, without people jumping up.

Those two countries in Western civilization are the United States and South Africa. In general, that is not the kind of public policy company I want to be in, but I think we really do have a real strong response.

Mr. **Jeffords**. I thank you. I think that is an important point. We are trying to come up with some guidelines, all along the line as to what is the responsibility of individuals, of States and the Federal Government in this area, and also in the retirement income area, which is very much related to this. Right now we are trying, in my Education and Labor Committee, to come up with a national policy on retirement so that we can try to give guidance to policymakers and the individuals as to what their respective roles are in furnishing assistance for our future.

Because if we don't, with the success that we are having in the medical field, and people living longer and longer, at some point the situation will be out of control. It will be beyond the ability of the future workers of this country to fund, not only the health care but also retirement, of those of us here today as we move into retirement.

I want to thank everyone for participating in today's forum. Before I close the hearings, I would like to offer anyone here who was in the audience that would like to express themselves or to participate to any extent the opportunity to do so.

If not——

[No response.]

Mr. JEFFORDS. All right, I will then formally close the hearings after, first of all, thanking the staffs that did so much work in putting this hearing together, and in particular Bernice Murray who just did an outstanding job, and Stacy Littlefield, of my Washington staff, who was here viewing the results of her efforts and ensuring that we had participation not only in Vermont but in Washington.

And also others who participated, Wendy Woodall, Anne Marie Stevens, Jeff Wennberg, and Patty Williams, who all helped to bring these hearings together.

And to Nancy Hobbs from the committee who was here from Washington.

I want to thank you all as well as my esteemed reporter who did a super job, and I thank you for coming. It will be up to you now to make sure that everybody in Washington gets an articulate recitation of our proceedings today.

Thank you very much.

[American Health Care Association report retained in committee files.]

APPENDIX

PREPARED STATEMENT OF HON. PATRICK J. LEAHY, A U.S. SENATOR FROM THE STATE OF VERMONT

I am pleased that Congressman Jeffords is holding this hearing on the DRG Prospective Hospital Payment System. I know that both consumers and providers of health care services are concerned that efforts to control costs will not be achieved to the detriment of our health care system.

We are fortunate to have Congressman Jeffords as a member of the House Select Committee on Aging. The needs of rural areas in the shaping of health care policy will be well served by his involvement in committee activities. I appreciate very much the opportunity to add my thoughts and comments to the record.

The cost of health care in this country worries all Americans—both young and old. We now spend more than $360 billion a year—$1 billion a day—on health care. This amounts to 11 percent of the gross national product, up from 4.4 percent just a generation ago.

Obviously, health care cost containment is, and must be, high on the list of policy priorities for attention by the U.S. Congress.

With the amount of money being spent, one would think every American would have the very best of health care. But that is not the case.

According to some, cost containment efforts made by the government and others, combined with an increased demand for better health care has actually resulted in a reduction in quality care for some and for near elimination of care for others.

The National Citizens Board on Inquiry Into Health in America, chaired by Dr. Arthur Fleming, released its findings last year. Dr. Fleming will be a familiar name to many attending this hearing. He was, for several years, the Commissioner of the Administration on Aging and oversaw the development of the aging network of state and area agencies on aging.

The Board concluded that, despite extraordinary medical advances, America's health care system has become "incapable of meeting ordinary health care needs."

Why should this be? In part, the very success of American medicine has contributed to the problem. The death rate is steadily declining while at the same time, life expectancy in this country has risen dramatically. Twenty years ago we could expect to live an average of less than 70 years—now the average male will live to age 76; the average woman will live to age 82.

Many diseases have been controlled or eliminated. Technology and better medicines make it possible to provide life saving surgery when once it could not have been attempted. Organ transplants, artificial body parts, and more, all contribute to an increased demand on the health care system and, increased costs.

Somehow, we must find a way to take advantage of these wonderful advances in medical science and technology, at a price we can afford.

The DRG system, regardless of its as yet unproven reliability, has helped to identify many of the specific issues which we must address.

Today, the several panels of experts will outline the problems and issues. Hospitals, physicians, health care professionals and service providers, oversight agencies—everyone who makes up the "health care delivery system"—are uniquely affected by the DRG system.

During the past few months, I have appreciated hearing from members of the Vermont health care community and from older people who have experienced the DRG system.

I am convinced that while there is merit to the DRG concept there are serious dangers as well. I feel strongly that we must get control of health care costs. But we must not place our elderly citizens in jeopardy to do so.

First, we must not achieve savings by making the elderly second class citizens when it comes to health care. Cost containment must be applied across the spectrum of users and payors if it is to be fair.

Second, we must be sure that savings are real. While there is evidence that the DRG system is resulting in fewer hospitalizations, earlier discharges, and therefore reduced Medicare reimbursements to hospitals, the savings may be offset by "cost shifting." We do not know yet just how much more we are paying in alternate kinds of care.

Third, we must see that adequate community health care and home health services are available, under Medicare and other insurance programs. Home health agencies are reporting a higher number of referrals and sicker clients than before DRGs. They are having a hard time meeting the demand. We cannot shut off one source of care and ignore the consequences.

Fourth, cost containment programs must take into account urban and rural differences. There is a delicate balance in any health care system between the numbers and location of hospitals, the disbursement of physicians, the availabilty of both medical and non-medical support services in the communities. In rural areas this balance is even more delicate. Our small hospitals and community based programs must not be penalized simply because they are small.

Fifth, the right and responsibility of physicians and other health care providers to exercise their best professional judgment on behalf of patients must not be jeopardized or intimidated. Program flexibility combined with honest, common sense, will guard against this. We must see that flexibility is part of any health cost containment program.

Sixth, there must be a built-in consumer role in developing and implementing cost containment programs. Consumers are virtually left out of the DRG system. This must change.

Seventh, currently, oversight and monitoring agencies pay more attention to cost savings issues than to quality of care. This, too, must change. There must be greater emphasis on the well-being of the patient.

Eight, administration of the program by federal agencies must be carried out in an evenhanded manner. Arbitrary regulations and unnecesarily complicated procedures must not be summarily handed down.

Finally, DRGs should be considered as only one means of bringing about cost savings. If they do not work or result in more hardship than benefit, they should be scrapped. In the interim, they are a help in holding down costs while we study other possible methods.

I am presently considering legislation which will address, in part, these and other problems related to health care cost containment.

I expect to actively support legislation to provide long term care insurance coverage, at an affordable cost to consumers.

I am looking into "small hospital" legislation which would give special consideration to small hospitals.

I am interested in the provisions of the Medicare Quality Assurance Reform Act, introduced by the House Select Committee on Aging. I am keeping an eye on several other health reform measures.

In closing, I am proud of Vermont's health care community and the manner in which they have come together to address these issues for the common good of all.

To the hundreds of elderly who have shared with me intimate and personal details of their own experiences with DRGs I am grateful. Their experiences have helped me to better understand the DRG progam and its affect on people and communities.

State of Vermont,
Office of the Governor,
Montpelier, VT, July 16, 1985.

Hon. James M. Jeffords,
House of Representatives
Washington, DC.

Dear Jim: The range of matters pertinent to the provision of long term care to our frail elderly and disabled citizens is, as you know, extremely broad. Your June 17 hearing enabled a wide variety of Vermonters representing broad interests to present their perspectives to you, Representative Hertel, and Delegate Blaz. I want to thank you for conducting this hearing in Vermont and to add to the record my thoughts about national policy regarding long term care.

Frankly, there is no apparent federal long term care policy, at least none that is applied consistently. We have created the Medicare system which, although increasing out of pocket costs make it difficult for beneficiaries, at least responds to the acute care needs of our older citizens. Once people need extended medical care, however, our national policy is, by effect, to direct people to impoverish themselves before providing them assistance under Medicaid.

If there is a consistent pattern to federal actions, it stems from budgetary considerations. The interplay between DRGs and home health funding provides a good example. As you heard on June 17 in Montpelier, there is little overriding argument in opposition to Medicare's prospective pricing system. It is designed to restrict the flow of needed Medicare dollars into hospital services. Little attention, reflective of the absence of long term care policy, has been paid to the consequences to our citizens being denied hospital admission or being discharged while still recuperating. These are people who are in need of care which may not be medical in nature. As you now, we have in Vermont a network of home health agencies which provide a wide range of needed services to people in their homes. Our towns contribute to home health agencies about half a million dollars annually to support services not reimbursable by Medicare, Medicaid or other sources. With revenue sharing on the federal chopping block, roughly 6% of the budgets of these agencies is at stake. In addition, HCFA has been tightening the availability of Medicare payment for home health services. A consistent long term care policy would foster greater provision of home health services for those persons spending less time in hospitals than before. Instead, federal level actions tend to deny both hospital care and home-based care for our neediest citizens, all in the interest of budgetary restraint.

We are examining ways in Vermont to coordinate and improve the availability of home-based services to persons needing long term care. The incentives on the federal level still encourage institutional forms of care, although for numbers of persons the total care provided by a nursing home exceeds what is needed. The level of care a person needs should not dictate where that care is given. An examination of how to provide proper incentives for the provision of home-based care is needed.

There is one particular area under current Congressional consideration that does address this incentives issue. The Medicaid Home and Community Based Waiver Program was created by Section 2176 of the Omnibus Budget Reconciliation Act of 1981. As written, the waiver program provided an important step toward permitting states to provide a balanced long term care program consisting of institutional and home-based elements. The administration's implementation of this program, however, appears to be thwarting that Congressional intent.

As you know, we have imposed severe limits in Vermont on increases in nursing home capacity. That restrictive policy has been an important one to pursue in the interest of fiscal restraint, among other reasons. Under HCFA's most recent formulation of the waiver rules, however, the fact that we have acted responsibility in this area hurts the prospects of our obtaining a waiver. Specifically, HCFA requires states, in estimating the size of the population in need of long term care services absent a waiver, to submit documentation on the number of nursing home beds that would have been created if no waiver were granted. Because we've put a lid on new bed creation, Vermont scores poorly under HCFA's formula. A state that has not controlled nursing home bed expansion can document more growth and obtain a waiver, despite probably having less need for one.

The consequence for Vermont, unless HCFA's interpretations are changed by regulation or statute, is an inability to participate in the waiver program. There are, of course, other features of that program and our own fiscal circumstances which would have to be considered by us before applying for a waiver. At this point, however, we most likely would not qualify even if we were to apply.

We are actively involved in examining Vermont's long term care system. We are confident that reorganizing and coordinating our system will result in better client-oriented services. These organizational and attitudinal changes, however, need to be complemented by reasonable as well as cost-efficient federal responses to the same population.

Thank you for the opportunity to offer these comments as part of the record of your June 17 hearing.

Sincerely yours,

MADELEINE M. KUNIN,
Governor.

VERMONT STATE NURSES' ASSOCIATION,
So. Burlington, VT, July 16, 1985.

Hon. JIM JEFFORDS,
House of Representatives,
Washington, DC.

DEAR CONGRESSMAN JEFFORDS: The Vermont State Nurses' Association appreciates this opportunity to present written testimony relative to the impact of prospective payment upon the health care of Vermont's elderly citizens and to make recommendations which might provide for improved health care services to this segment of Vermont's population.

The Vermont State Nurses' Association supports the reduction of health care costs as implemented through the newly instituted prospective payment system (DRG's). The Association believes that the difficulties confronting the health care consumers and providers are less a fault of prospective payment than of shortcomings in the health care system which have been there all along and have been brought to light by the DRG's.

It is recognized that the first level of the so-called "safety net" for the ill, the handicapped and the elderly, is the family; and that every effort should be made to increase support to the family in its effort to avoid institutionalization of a family member. Recently some Vermonters have developed foster home and day care situations on a demonstration basis for our elderly citizens. The Vermont State Nurses' Association would support and expand these alternatives to avoid premature nursing home placement; this is particularly important for those elderly who lack funds and family support.

Many people in the older, elderly age bracket (80-100 years) no longer have family or friends to act on their behalf. Many have outlived their children. This is the group that most frequently has problems with the system. Often members of this group are put into nursing homes prematurely due to lack of care alternatives. They need a support system which will provide alternatives which keep them at home and in the community.

The system of home health agencies which is now well established in Vermont and which provides a wide range of services in the home has always and still does, receive a very small percentage of the health care dollar in Vermont; in addition, the fiscal intermediary is becoming even more restrictive in payment for home health services; for example, the definition of "homebound" is much less flexible than in the past, thereby eliminating medicare reimbursement for some situations which were once eligible for home health care. Because of early hospital discharge, due to DRG's, people are leaving the hospital sicker than formerly and intermittent nursing care in the home, reimburseable by medicare, is insufficient to meet the elder patient's needs. Acute care in the home is becoming increasingly technical necessitating more than a once daily nursing visit; earlier hospital discharge frequently mandates the need for short term 24 hour a day care by a variety of levels of caretakers; there is no method of reimbursement for this. Medicare reimbursement should cover the more intensive nursing care resulting from shorter hospital stays.

Not only are people leaving the hospital sicker; they are also coming into the hospital in much sicker condition; because of fear of not qualifying for admission or coverage by Medicare, the patient waits until the situation is near, or at, crisis. An example is a man with diabetes whose wife worked to provide the couple with food and shelter; he refused medical care because of inability to pay and was finally admitted to hospital with diabetes totally out of control gangrene of portions of this feet, and finally ended up in hospital intensive care unit for one week. Medicare reimbursed preventive home nursing care for this couple would have saved immeasurable human suffering and many acute care dollars.

More funding needs to be made available for health promotion and prevention of illness and disability at the community level. It is the professional nurse who is coordinator and provider of these services; currently, there is no reimbursement for this type of service. These community based preventive services, can save acute health care dollars and enhance the quality of life for Vermont's elderly citizens.

When government agencies and insurance companies took over paying the individuals bills for health care, costs escalated beyond everyone's ability to pay. Costing out specific health care services for the individual, regardless of who pays the bill, can cut costs. When providers and recipients of care know the cost of time and supplies, they will become more cost conscious. In general, Vermont hospitals include nursing service in the room rate; patients who receive 3 hours of skilled professional nursing service pay the same amount as the patient receiving 8-12 hours of professional nursing time; this is unfair to the payor of the bill and contributes to escalation of health care costs. Nursing care is the basic service for which people are admitted to hospital and nursing home care; and people have the right to know what this service costs.

Historically, prior to the depression years and even into the 1950's, nursing, like medical practice was predominantly a private duty, independent contractor service. Nursings shift from the privately employed situation to that of the institutional employee has been the result of social, economic and technological changes which have placed increasing societal reliance on institutionalized health care, massive programs of public support, and the forging of economic bonds between and among physicians, the insurance and hospital industries, and the government itself. As of January 1985, more than 18 states have passed legislation which either requires or makes optional that insurers make available direct insurance reimbursement for non-institutional nursing services. Reimbursement is for services which are within the lawful scope (state law) of nursing practice. These are considered to be major pro-consumer laws: 1) consumers get access to nursing services provided outside of the hospital and agency organizational setting; and 2) direct access to cost-effective nursing services begins to respond to the issue of reducing health care costs. Current federal laws and guidelines limit the nurses ability to be reimbursed directly for nursing service.

In conclusion VSNA would like to recommend the following:

(1) Provision of funds to support and expand home and community alternatives for the elderly i.e. day care, foster care and respite for family care givers.

(2) Changes in federal laws and guidelines to allow reimbursement for teaching and preventive home nursing care, which can prevent illness and disability and decrease admission to hospitals.

(3) Continued cost containment with adjustment of DRG rules to allow a flexible interpretation for reimbursement during the acute care hospitalization of the frail and elderly.

(4) Support for funding that covers the intensive professional nursing care required by early discharges and outpatient surgeries.

(5) Third Party reimbursement for health care to the elderly should follow the patient whether at home, in alternative community home setting, nursing home, or hospital; and payment systems should provide incentives for the most appropriate setting and level of care.

Thank you for considering the recommendations of the Vermont State Nurses' Association.

Sincerely,

ELAINE SUMNER, *R.N., Director.*
PAT ALLEN, *R.N., President.*

STATEMENT OF VINCENT ELLIOTT

SUBJECT: MEDICARE/MEDICAID AND DRG

Out-of-Control health care costs are clearly a major factor in the lives of Seniors and the Taxpayers. With health care costs rising at rates far outstripping inflation, cost containment of health care programs is a priority for everyone. One reform enacted by Congress was the (DRG) so called, for Diagnostic Related Groups. Medicare reimbursement to the Medical providers is now based on a set rate established for each health care problem. In making this change costs have been reduced, *however an emerging condition of concern appears, that is a "gap" has been created where people with a health care problem of greater need than that spelled out under the DRG system are unable to obtain adequate care elsewhere. (Quote, Jim Jeffords Senior Citizens update, April 1985 in part).*

As an example of the foregoing I will present the case of a *Stroke Victim.* The incident took place out of State. Hospitalization was limited to 2 weeks maximum, *DRG diagnostic group.* Patient paralyzed in part. Transfer made to another hospital in another area, with anticipation of more intensive treatment available. DRG group allocation again limited to 2 weeks maximum. Transfer again made to what was defined as *Rehabitation specialization center.* In this case DRG was extended to 4 weeks maximum. In the first instance the total cost, Hospital and Doctor was $5000.00 plus. In the second instance the total cost was in excess of $7700.00 dollars and the third instance the costs were close to $1600.00 dollars. The victim was at the time 63 years of age, 15 months short of Medicare, and assumed to be covered by BC/BS. They limited their total responsibility to $20000.00 and stopped payment at that point. This was divided 90% hospital, 10% doctors. Medical report transmittals from one institution to another were rejected and *re-peat examinations and test were conducted over again.* All of which escalated costs with no regard for *Cost Containment.*

After two months as described the patient was transfered to the home area, and a local hospital. The events described on the following page bring out data more significant to follow up treatment of the health care problem.

After another month of hospital treatment at a local hospital and under the care of the patients physician of the prior 15 years, discharge followed, and entry was made in a local convalescent home, under *Medicaid*. The *entire history of events prior to this time were described to the administrator* of this institution. Questions were posed regarding the capability of continued support in all aspects of treatment similar to that previously administered and *affirmative answers were offered*. After about 2 months of residence at this home it was apparent that more dialogue than action was taking place, the patient was discharged and brought home, with approval of the doctor. One month of this was the extent of myself alone to handle a case of this nature. Entry was again made to the convalescent home. The patient was visited on a daily basis as in the past, and the same problems that were present previously were taking place. *These consisted of inadequate staffing, non-fulfillment of pledges made for such items as therapy and extended periods without individual exams, tests and observation as spelled out upon entry*.

As a result of the foregoing omissions the patient has required the re-entry first in February and again in April to the local hospital, and both times *due in part to lack of visitations by medical staffing of a level high enough to qualify in respect to the nature of the problem*.

In each instance there was no question that more intense care was required, and this information was transmitted directly to the *administrator*. His reply always spelled out that he was adequately staffed *within budget*, when many nights only 2 attendants and one nurse were on a floor that has 51 beds, primarily handicapped people late in years. The concept of this *administrators responsibility* has been described as one who simply *delegates authority* to others. He is present on the premises during the daytime only, and then far short of 40 hours. What goes on the other 130 hours of the week is immaterial. (Academic qualifications in lieu of experience)

In the February re-hospitalization DRG was again instituted and discharge was mandated after 2 weeks. In the April instance the patient became eligible for Medicare, after the 2 weeks were up other *Groups* not related were used to provide extended time. Since this latter period I have had the patient home but even though she has done well here I have reason to believe that a return to convalescent custody will be a *merrygoround*.

The gap is probably the greatest here of any *Related Group* potential.

On the prior 2 pages I have described the history of one case that is, granted, complex in nature, and has run into thousands of dollars, some of which was insurance company risk. The balance has been both public and private funded. I would like to suggest an alternative to the two latter methods that are in current use.

Compile the statistics from Page 1 and we arrive at a figure in excess of $39000.00 of which as stated BC/BS limited themselves to $20000.00 maximum.

Page 2 totals are greater by far in Public Money (Social Welfare) and a token contribution from the patient. I am informed that this state pays a fee of $50.00 dollars per day for a bed in the type and classification required by this patient. The patient pays in relation to their financial means. Both of these figures are *Medicaid support items*. In addition this State allows a patient to be released to the home a maximum of 24 overnight visits in a 12 month period. Any overnight stays in excess are charged to the patient at a figure in excess of $50.00 per per night. This money is payable to the convalescent operator as an unused bed charge. Using the values quoted over $20000.00 a year is paid to the nursing home for each bed available. Greater fees are charged for higher level care.

Another aspect of significant interest to the family in many cases of this type is the attitude expressed by nursing home management when problems arise. The general response will be that "*there are other places to take your relative*".

Returning to the suggestion of an alternate method that would be possible in many cases and this patients case is a good example, recalling that the purpose behind this article is *Cost Containment*. I suggest a revision in the Medicaid program wherein a patient could be discharged in the custody of a relative for an extended period at intervals or as often as possible and when the relative found it no longer possible to conduct this benefit, then return the patient to the nursing home. This would also assure that proper medical support was being provided, insofar as most nursing homes are no more than *Custodial Care*, and incidents similar to that described in this communication could possibly be averted.

The prior problem could have been fatal and is described in Medical Terms as De-Hydration with Secondary Lithium Toxicity and Hemi Hallismus with other complications due to conditions beyond the scope of Nursing home custodial care level of treatment.

PS to the enclosed communication;

Medicaid is a subject that the Federal Gov't has washed its hands of and its associated program Medicare has been watered down to a level far below that intended when the original plans were developed.

My investigation of Medicaid has disclosed that some states do not provide any program at all. Other states provide a plan with funding delegated to the county level which does not offer very much aid, insofar as the potential would not exist in a rural area.

Another factor with reference to what is available here in vermont literally puts a lien on the property or any real estate that involves the patients name. This means that a husband or wife who are unfortunate enough to be the victim of such a circumstance find their hands tied. Their assets are froze, and in retirement and as a senior Citizen this is a very depressing status to try to live with.

As stated on page 3 of the case description, home treatment provides an alternative to nursing home confinement, but places a restriction of almost unbearable strain on the relative. While trying to live with this situation numerous calls are received from the so-called do good agencies offering services that involve activity that is associated with a commercial venture one way or another.

i.e. Senior Lunch programs, Federal funding, commercial vendor. Visiting Nurses, Commercial sales offering associated. Social Worker, Providing brokerage service for other home needs from housekeeping to patient setting at fee's far in excess of Federal minimum wages.

In other words from the writers experience most of these so called do good Federal programs have been manipulated in one way or another to benefit private enterprize. In summary I would like to point out that there are probably many cases of the same nature as the one experienced in this article that could be partly resolved in home care if there was a program developed where the patient could be placed in the custody of an out-patient type nursing home facility for a few hours a day, or as required, in order that the relative or who-ever could be permitted to have some relief from the 24 hour a day responsibility involved.

This proposal, would do a lot to eliminate the void that is presently taking place in the Hospital v/s Nursing Home criteria.

○